Graduate of King + Queen's College
of Physicians in Ireland,
11th January 1889

# PORTFOLIO

OF

# DERMOCHROMES

BY

PROFESSOR JACOBI
Of Freiburg im Breisgau.

English Adaptation of Text

BY

J. J. PRINGLE, M.B., F.R.C.P.
Physician to the Department for Diseases of the Skin at the Middlesex Hospital, London.

VOL. II. (PARTS 3 AND 4)



LONDON
REBMAN, LIMITED
129, SHAFTESBURY AVENUE, CAMBRIDGE CIRCUS, W.C.

NEW YORK AGENTS: REBMAN COMPANY
10, West 23rd Street, Corner of Fifth Avenue

1903

Entered at Stationers' Hall

# ALPHABETICAL LIST OF SUBJECTS FOR PART III.

## AFFECTIONES CUTANEÆ.

## NUMERICAL LIST OF SUBJECTS FOR PART III.

### AFFECTIONES CUTANEÆ.

| PLATE. | FIG. | |
|---|---|---|
| XLIII. | 79 | Pemphigus neonatorum. |
| „ | 80 | Dermatitis herpetiformis (Duhring). |
| XLIV. | 81 | Acne vulgaris faciei. |
| „ | 82 | Acne, comedones dorsi. |
| XLV. | 83 | Sycosis. Folliculitis barbæ. |
| „ | 84 | Acne varioliformis. Acne necrotica. |
| XLVI. | 85 | Acne rosacea. |
| „ | 86 | Rhinophyma. |
| XLVII. | 87 | Toxicodermia ex usu Bromi. |
| „ | 88 | Toxicodermia ex usu Iodi. |
| XLVIII. | 89 | Toxicodermia ex usu Arsenii (Hyperkeratosis palmaris). |
| „ | 90 | Toxicodermia ex usu Antipyrini. |
| XLIX. | 91 | Toxicodermia ex usu Balsami Copaivæ. |
| L. | 92 | Sclerodermia circumscripta frontis. |
| „ | 93 | Sclerodermia circumscripta brachii. |
| LI. | 94 | Vitiligo, (Leucodermia). |
| „ | 95 | Chloasma. Melanodermia uterina. |
| LII. | 96 | Nævus papillaris pigmentosus. |
| LIII. | 97 | Nævus vascularis, (Teleangiectodes). |
| „ | 98 | Nævus linearis. |
| LIV. | 99 | Verrucæ seniles et cavernomata senilia. |
| LV. | 100 | Verrucæ planæ volæ manus. Warts. |
| „ | 101 | Papillomata. Condylomata acuminata. |
| LVI. | 102 | Mollusca fibromata. |
| „ | 103 | Atheroma multiplex scroti, (Cystes sebaceæ). |
| LVII. | 104 | Mollusca contagiosa faciei. |
| „ | 105 | Keloid. |
| LVIII. | 106 | Xanthoma. |
| „ | 107 | Xeroderma pigmentosum. |

# ALPHABETICAL LIST OF SUBJECTS FOR PART IV.

## AFFECTIONES VENEREÆ.

## NUMERICAL LIST OF SUBJECTS FOR PART IV.

### AFFECTIONES VENEREÆ.

| PLATE. | FIG. | |
|---|---|---|
| LXXII. | 131 | Alopecia syphilitica. |
| LXXIII. | 132 | Syphilis (Sclerosis præputii). |
| ,, | 133 | Syphilis (Sclerosis digiti). |
| ,, | 134 | Syphilis (Sclerosis linguæ). |
| LXXIV. | 135 | Syphilis (Sclerosis labii superioris). |
| ,, | 136 | Syphilis tertiaria volæ manus. |
| LXXV. | 137 | Syphilis maculosa (Roseola). |
| LXXVI. | 138 | Syphilis maculosa recidiva (Roseola recidiva). |
| LXXVII. | 139 | Syphilis papulosa lenticularis. |
| ,, | 140 | Syphilis papulosa mucosæ oris. |
| LXXVIII. | 141 | Syphilis papulosa orbicularis. |
| ,, | 142 | Syphilis papulo-squamosa. |
| LXXIX. | 143 | Condylomata lata. |
| ,, | 144 | Syphilis pustulosa. |
| LXXX. | 145 | Syphilis lichenoides. |
| ,, | 146 | Leucoderma syphiliticum. |
| LXXXI. | 147 | Syphilis maligna (Rupia syphilitica). |
| ,, | 148 | Syphilis frambœsiformis. |
| LXXXII. | 149 | Syphilis tubero-serpiginosa. |
| ,, | 150 | Syphilis tertiaria. |
| LXXXIII. | 151 | Syphilis gummosa linguæ. |
| ,, | 152 | Syphilis gummosa nasi. |
| LXXXIV. | 153 | Syphilis ulcero-serpiginosa montis veneris. |
| LXXXV. | 154 | Syphilis hereditaria (Pemphigus syphiliticus). |
| ,, | 155 | Syphilis hereditaria (Ossium nasi). |
| LXXXVI. | 156 | Ulcera mollia. |
| ,, | 157 | Ulcus molle phagedænicum (gangrænosum). |

# Pemphigus Neonatorum.

Plate XLIII., Fig. 79.

Pemphigus neonatorum is an infective disease which almost always occurs in epidemics; it attacks especially new-born, but occasionally older, children. Vesicles and blebs, usually flat on the top, appear with or without fever on skin which may be normal or reddened, and the rete Malpighii soon becomes exposed (Fig. 79). As the disease progresses relapses may occur; but, on the other hand, it may rapidly recover after a single outbreak. Complications may take place, due to secondary infections.

The **Etiology** is not accurately determined; the distribution of the eruption is in no sense characteristic.

The **Differential Diagnosis** from syphilitic pemphigus of the newly born may be established by the localization in the latter of the blebs on the palms and soles, as well as by concomitant evidences of syphilis.

The **Prognosis** is usually favourable, but epidemics of unusual severity sometimes occur.

The **Treatment** consists chiefly of protecting the blebs by powders, and in the prevention of secondary infection by suitable dressings, or by baths to which antiseptics have been added.

Fig. 79. Model in Lesser's Clinic in Berlin (Kolbow).

# Dermatitis Herpetiformis.

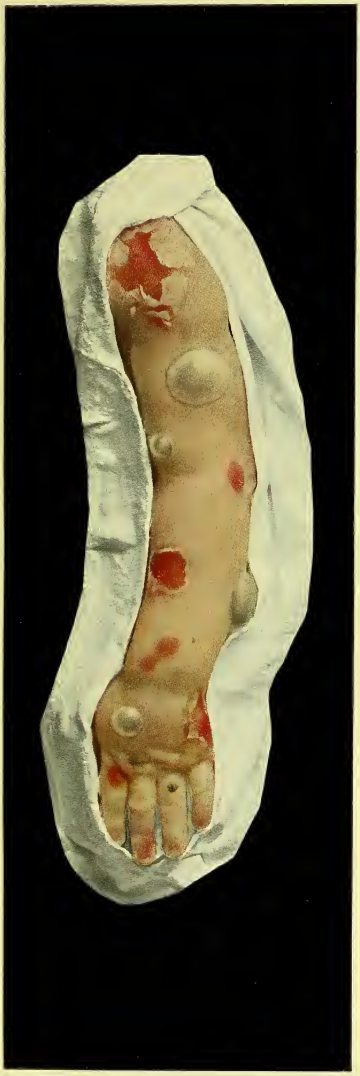
## (*Duhring*).

PLATE XLIII., FIG. 80.

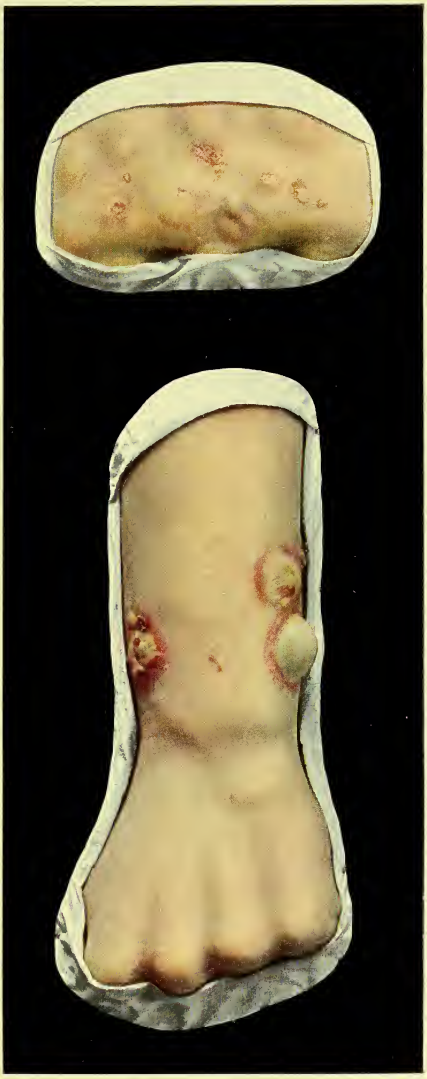
The disease called Dermatitis herpetiformis, so distinctly described and differentiated by Duhring, is characterized mainly by the multiformity of its manifestations. Along with urticarial wheals, erythema and papules occur, but especially blebs of various size, accompanied by nervous symptoms and extremely violent itching. The process may be arrested in any stage of its evolution, or blebs may appear without preliminary lesions. The multiformity of the morbid picture is increased by itching, rubbing and secondary infections. As a rule, frequent relapses follow one another, and the disease extends over an extremely prolonged period; but, despite the fact that the patients become greatly exhausted by the severe subjective symptoms and the frequent relapses, the prognosis—in contrast with that of pemphigus—may be regarded as generally favourable.

The **Etiology** is unknown; but a neurosis is accepted, in many quarters, as its cause.

The **Diagnosis** can, as a rule, be established only after long observation, on the grounds of the



No. 79. Pemphigus neonatorum.



No. 80. Dermatitis herpetiformis (Duhring).

polymorphism, the intense itching, the repeated relapses, and the benign course of the disease.

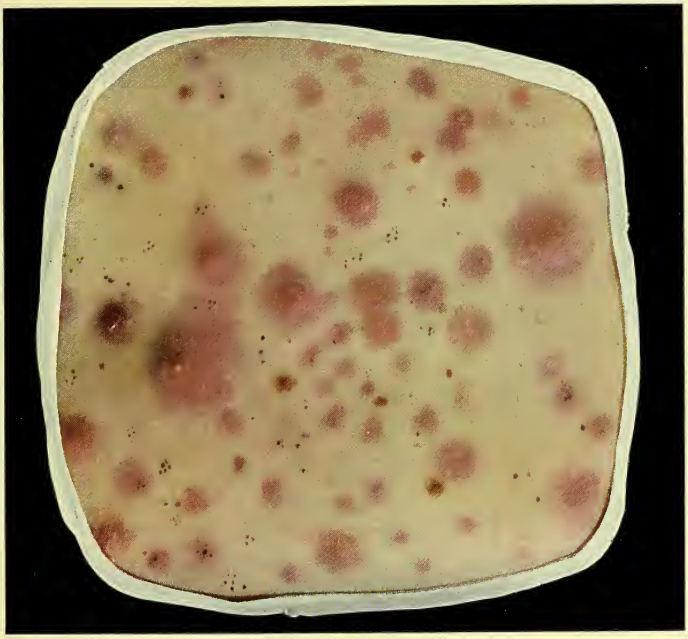
**Treatment** can only be symptomatic; nervous phenomena must be combated by nerve-tonics, and the sufferings of the patient alleviated by baths and the application of antipruritic remedies. Lotions containing alcohol, sulphur baths and tarry preparations often act favourably; as may the internal administration of arsenic and strychnine.

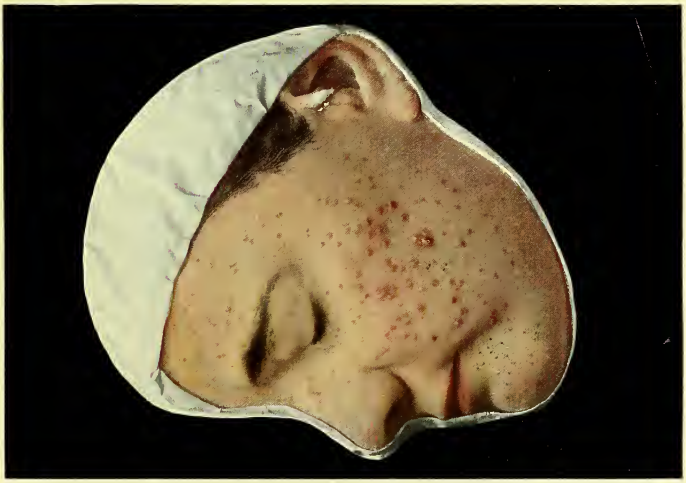
Fig. 80. Model in Saint Louis Hospital in Paris (Baretta). Tenneson's case.

# Acne Vulgaris.

Plate XLIV., Figs. 81, 82.

The commonest form of disease included under the name of Acne—or chronic inflammatory folliculitis—occurs in young persons, especially about puberty, in whom, owing to infection of the inspissated contents of the sebaceous ducts (*Comedones*), very obstinate suppurative changes occur, of widely varying depth and extent. Single acne-nodules, the contents of which consist of necrosed comedones and pus, often have a scab at their summit. After the evacuation of their contents they generally heal, leaving a scar or cicatricial pit, sometimes with pigmentation; but new eruptions always appear in the neighbourhood, so that the disease not only lasts for years, but may finally give rise to marked disfigurement. The seats of the affection are principally the forehead, nose and adjoining parts of the cheeks, the chin, (Fig. 81), the chest, and the upper part of the back. In the latter situation large, deep infiltrates not infrequently form from coalescence of the acne nodules (*Acne indurata*), which leave irregular or keloid-like scars after their disappearance. Palpation of the skin of the face of patients suffering from acne often reveals the presence of a large number of nodules lying deeper than those visible on the surface; and the complexion is generally of a special, pasty, bloated appearance.





No. 81. 82. Acne vulgaris.

The **Etiology** of Acne is not yet fully cleared up; many morbid processes conspire to favour the existence of the disease. Thus, gastro-intestinal disturbances often coexist, but a peculiar seborrhœic condition is frequently present, which gives rise to the formation of comedones, and these, in their turn, are converted into acne-pustules by the usual pyogenetic organisms. The specific significance attributed to various bacteria found in the pus of acne-pustules is contestable.

The **Diagnosis** of Acne vulgaris is easily established by the presence of comedones and acne-pustules, and of all the intermediate stages between them. Somewhat similar syphilides may generally be differentiated without difficulty; and the futility of antisyphilitic treatment, in dubious cases, eventually clenches the diagnosis.

The **Prognosis** of Acne may be regarded as favourable, but the malady is often of very protracted duration.

The **Treatment** must include the removal of all digestive disturbances which may be present, but we have never seen any useful results from strict dieting alone. Internal medicaments, such as ichthyol, purgatives and yeast, have yielded equally unreliable results. The local treatment must be carefully selected according to each individual case; for, whilst in some persons any powerful remedy provokes violent reaction, strong stimulating salves or pastes must be used in others.

First of all, comedones must be removed by expression, and the infiltrates and abscesses emptied by incision or poultices, or softened by mercurial plaster. The seborrhœa and associated comedo-formation ought

to be combated, and this is best done by sulphur pastes or by washing; sulphur acts less satisfactorily in the form of ointments. The employment of sulphur and ichthyol soaps, or of spiritus saponis alkalinus and hot water, accomplishes the removal of excessive fat and opens the follicles, so that their contents can be evacuated. Subsequent vigorous scaling of the skin is of use, and may be carried out by means of resorcin-sulphur or naphthol (Lassar) paste, or by painting with tincture of iodine or iodine-glycerine. It is to be noted, however, that after the employment of any irritating application sufficient time must be allowed for complete disappearance of all signs of inflammatory reaction. In the intervals powders, cold creams, lanolin-cream, and similar substances may be used. In persons with very delicate skins the greatest care must be taken to begin with weak sulphur or resorcin-sulphur pastes, in order to reduce the irritability of the skin gradually.

After the cure of acne-nodules the formation of comedones must be prevented by washing with alcohol or warm water, using sulphur or 'marble' soap. Sulphur-baths and touching the lesions with Vlemingkx' solution are especially worthy of recommendation in acne of the chest and back, but the latter remedy is to be avoided in the treatment of acne of the face.

Figs. 81, 82. Models in Neisser's Clinic in Breslau (Kröner).

# Folliculitis Barbæ. Sycosis.

Plate XLV., Fig. 83.

Isolated or confluent pustules and nodules, penetrated by hairs and usually covered by scabs, sometimes result—especially in the male sex—from eczematous processes, or may develop without such preliminaries, around the hair-follicles of the beard. The seat of predilection of sycosis is—as has been just stated—the beard (Fig. 83); but in rare cases the eyebrows, eyelashes, nasal, axillary and pubic hairs are involved; while in very exceptional cases the scalp is similarly affected. The malady is extremely chronic, and the individual follicular lesions heal only after the death of the hair and the formation of scars; while new foci of disease always arise, resulting in its protracted duration. The immediate causal factors of sycosis are acknowledged to be the common pyogenetic cocci, but the ground is usually prepared for them by some local irritation. After the disease has persisted for a long time the separate follicular lesions coalesce and form large infiltrated patches, at the margin of which only can the various stages of its development be recognised.

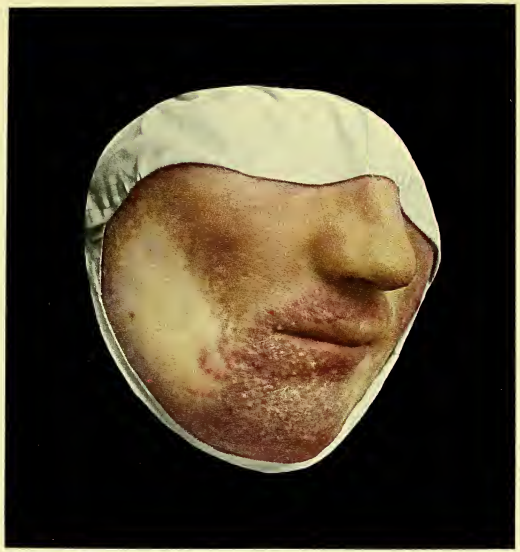
The **Diagnosis** is usually made without difficulty by the localization, the chronic course and the existence of nodules pierced by hairs. Ringworm of the beard is to be differentiated from sycosis by the presence at the margin of circular groups of lesions, by

the greater amount of infiltration, and, finally, the demonstration of the fungus is decisive.

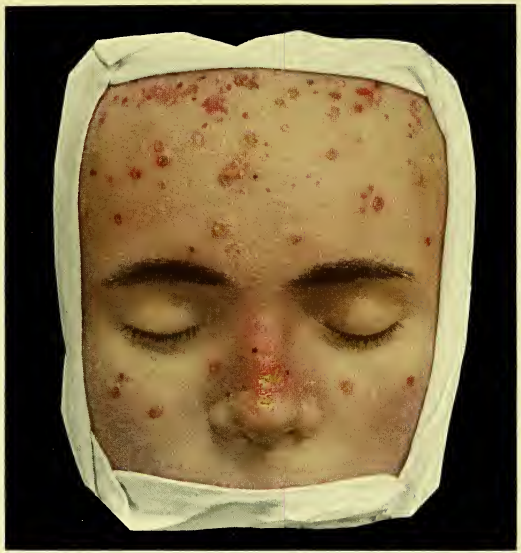
The **Prognosis** must be guarded on account of the extremely frequent relapses.

**Treatment.**—All circumstances which favour invasion by cocci must first be attacked—*e.g.*, eczema, nasal catarrh, etc. Then epilation must be practised to afford an outlet for pus, followed by poultices or moist dressings containing resorcin, 1 per cent., acetate of aluminium; corrosive sublimate (1 : 5,000); boric acid or ichthyol. Large abscesses must be opened and, ultimately, extensive persistent infiltrates assisted towards absorption by scarification, scaling pastes or salicylic and soap-plasters. Quite recently light-treatment has given good results; it must be administered with the greatest caution.

Fig. 83. Model in Neisser's Clinic in Breslau (Kröner). The patient was treated by radiotherapy, and the affected parts healed completely with a smooth scar.



No. 83. Folliculitis barbae (Sycosis).



No. 84. Acne necrotica (varioliformis).

# Acne Necrotica.

## Acne Varioliformis.

Plate XLV., Fig. 84.

Small, reddish papules which soon show in the centre roundish, necrotic points of a yellowish, brownish, or blackish colour, sometimes appear on the forehead at the margin of the scalp, more rarely on the chest and back. The epidermis in the process of healing spreads inwards from the margin under the central necrotic scab; and after the scab separates a sharply defined, round cicatrix is left, strongly reminiscent of a small-pox scar, the margin of which gradually fades in colour (Fig. 84). The lesions are localized in the follicles, and sometimes cause considerable pain. The disease is comparatively rare; it occurs chiefly in men and in successive crops, so that it may last for years.

The **Etiology** is unknown, but an infection of some sort is supposed to exist.

The **Diagnosis** is not difficult after the formation of the typical scars. A form of syphilide is especially to be distinguished from acne varioliformis, but it usually produces deeper destructive changes.

Fig. 81. Model in the Freiburg Clinic (Johnsen).

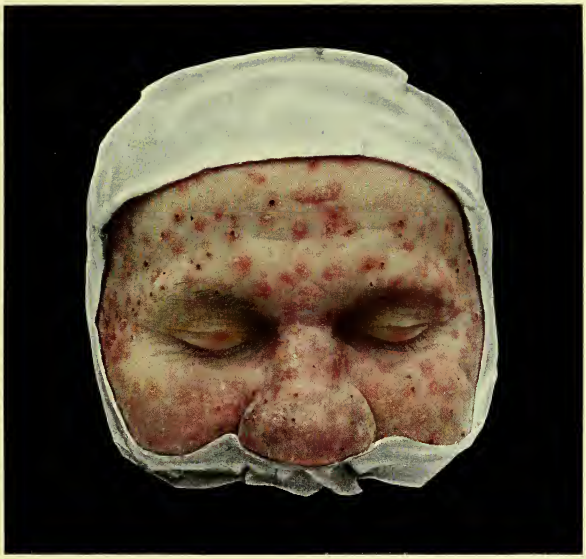
# Acne Rosacea.

## Rhinophyma.

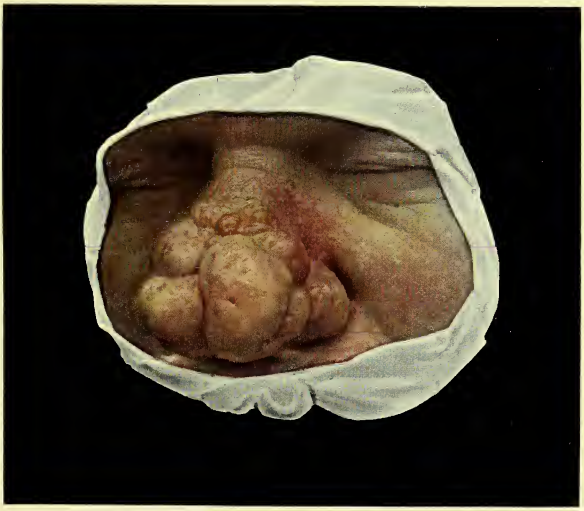
Plate XLVI., Figs. 85, 86.

The disfiguring disease called Acne rosacea, or simply Rosacea, occurs in persons of middle or more advanced age on the face, chiefly on the nose. Like Acne vulgaris, with which it is often associated, it frequently is superimposed upon a seborrhœic basis. In its lower grades it consists merely of some reddening of the skin dependent on dilatation of the surface bloodvessels. In severer cases acneiform nodules form, which do not usually, or even frequently, suppurate. In the highest grades of the disease, besides redness or bluish-red discoloration of the skin, a manifest dilatation, with tortuosity of the cutaneous bloodvessels, takes place, while marked hypertrophy of the sebaceous glands causes the formation of lumps, and results in the nose assuming a swollen, dissipated appearance (Fig. 86). This very chronic affection attains its severest forms in men only.

As regards **Etiology,** Rosacea is very often considered as mainly due to alcoholic excess, but disorders of the gastro-intestinal tract, of the uterus in women, or, finally, changes in the nasal mucous membrane, may be the starting-point of the condition. A specially favourable causative agent is prolonged exposure to cold air, wind and vicissitudes of weather. Engine-drivers, cabmen, etc., are thus frequent victims.



No. 85. Acne rosacea.



No. 86. Rhinophyma.

The **Diagnosis** may generally be made without difficulty. Tubercular syphilides are of different tint and have a tendency to break down; while other symptoms of syphilis are almost always present. Typical nodules are to be seen in lupus vulgaris. In lupus erythematosus the morbid process spreads at the margin, with firmly adherent scales, while healing takes place in the centre.

The **Prognosis** is fairly favourable in the early phases of the malady; in severe cases it is usually dubious.

**Treatment** consists of first curing internal disorders and of eradicating ascertainable morbific agents.

The local treatment is very similar to that of mild and moderate forms of acne vulgaris—*e.g.*, rubbing in sulphur-resorcin pastes, or sulphur and ichthyol soaps, while in severe forms scaling pastes are very useful. Hyperæmia may be effectively combated by the use of a 40 per cent. resorcin paste till the skin is desquamated; and, subsequently, dilated bloodvessels may be slit up or destroyed by micro-thermocautery. Scarification and needling are often of use. In Rhinophyma the outgrowths may be removed with the knife till the normal form of the nose is restored, and the wounds generally heal easily by extension of epithelium from that of the sebaceous glands.

Figs. 85, 86. Models in Neisser's Clinic in Breslau (Kröner).

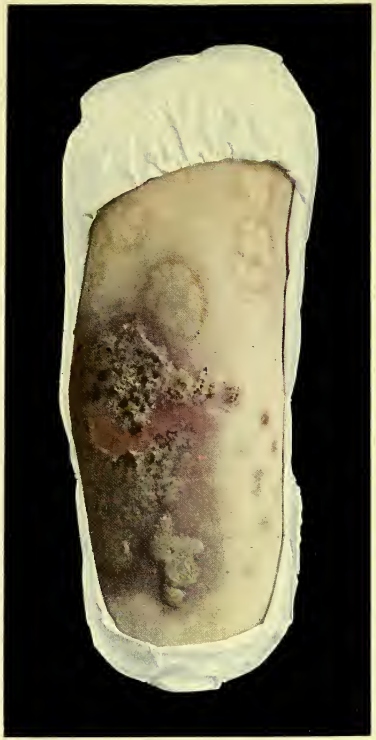
# Toxicodermiæ.

## Medicinal Rashes.

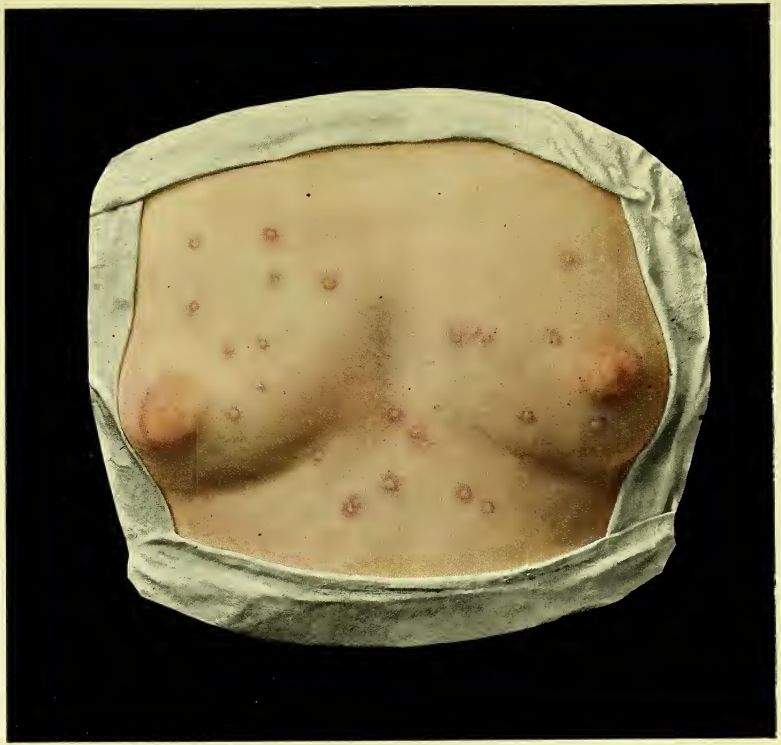
Plates XLVII.-XLIX., Figs. 87-91.

Eruptions appear in some specially-predisposed persons after the absorption of certain medicinal substances, whether they get into the circulation by the mouth, the anus, by inhalation, or through the skin. These eruptions vary greatly in intensity and character, and may manifest themselves after the smallest doses, or, on the other hand, only after large quantities of the substances in question have been absorbed and eliminated by the follicles. Polymorphism is considered to be specially characteristic of such rashes; thus, they may be mere localized erythemata, macules, or papules, or may become generalized, hæmorrhagic, vesicular, and bullous forms of dermatitis. In some persons every dose of the drug evokes an eruption which in all subsequent attacks is usually localized in the same situation (mouth, genitals, extremities, more rarely the trunk); in others the drug may be tolerated at times. After stoppage of the causative drug recovery soon takes place, but pigmentation often remains behind.

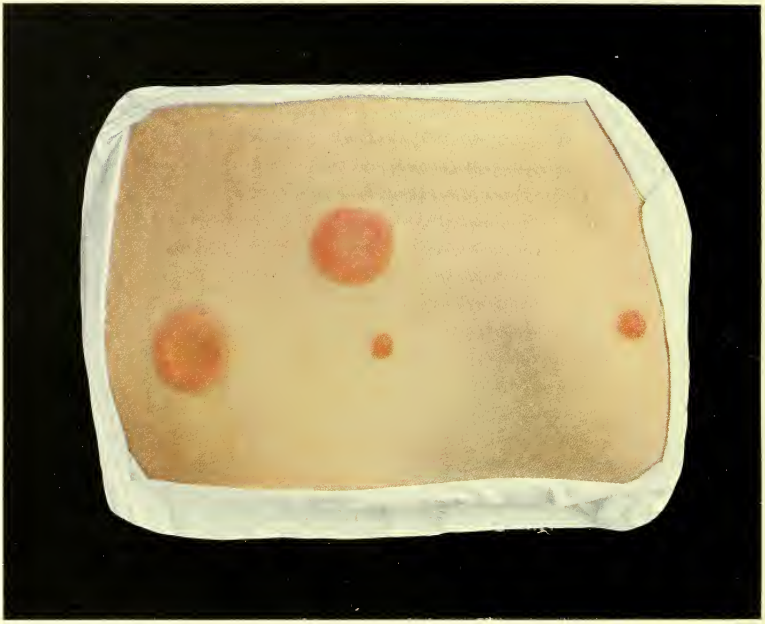
*Antipyrin* must first be mentioned among those remedies which rapidly cause an exanthem (Fig. 90) in the form of coalescing, large, urticarial-like wheals on the skin, and blebs on the mucous membranes.



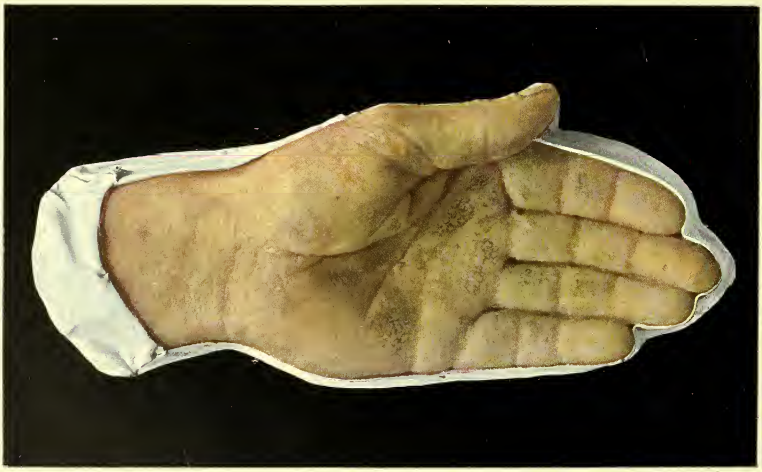
No. 87. Toxicodermia ex usu Bromi.



No. 88. Toxicodermia ex usu Jodi.



No. 89. Toxicodermia ex usu Antipyrini.



No. 90. Toxicodermia ex usu Arsenii (Hyperkeratosis).

*Quinine*, besides a diffuse erythema with subsequent desquamation, also frequently provokes a hæmorrhagic eruption. *Opium* and its alkaloids, *Iodine* (Fig. 88), Mercury, Atropine, Salicylic acid, Turpentine and various *Balsams* (Fig. 91) all may cause similar symptoms. Hydrate of Chloral, more rarely Phenacetin, and Antifebrin may also give rise to eruptions, while Tuberculin and the anti-toxin of Diphtheria must also be mentioned. *Iodine* and *Bromine* give rise to toxicodermiæ chiefly after prolonged administration, the former in the shape of pretty-acutely eruptive, acneiform pustules which closely resemble acne vulgaris, while the latter provokes peculiar papular and papulo-pustular outgrowths on the skin (Fig. 87).

The appearance of zoster is a special effect of the administration of *Arsenic;* arsenical keratosis (Fig. 89) also occurs, in which the palms are covered with thick, dirty-grayish, horny masses, among them being very numerous cornified spines, originating round the orifices of the sweat-ducts. It is worthy of note that carcinoma may, although rarely, develop from arsenical keratosis. Finally, dark pigmentation, situated chiefly on the trunk, must be mentioned as another result of the use of arsenic.

The **Diagnosis** of medicinal rashes is often very hard to establish, unless the history given by the patient is clear. One's thoughts must always turn to a toxic rash when a polymorphous eruption appears, which does not accord with any recognised type of skin-disease.

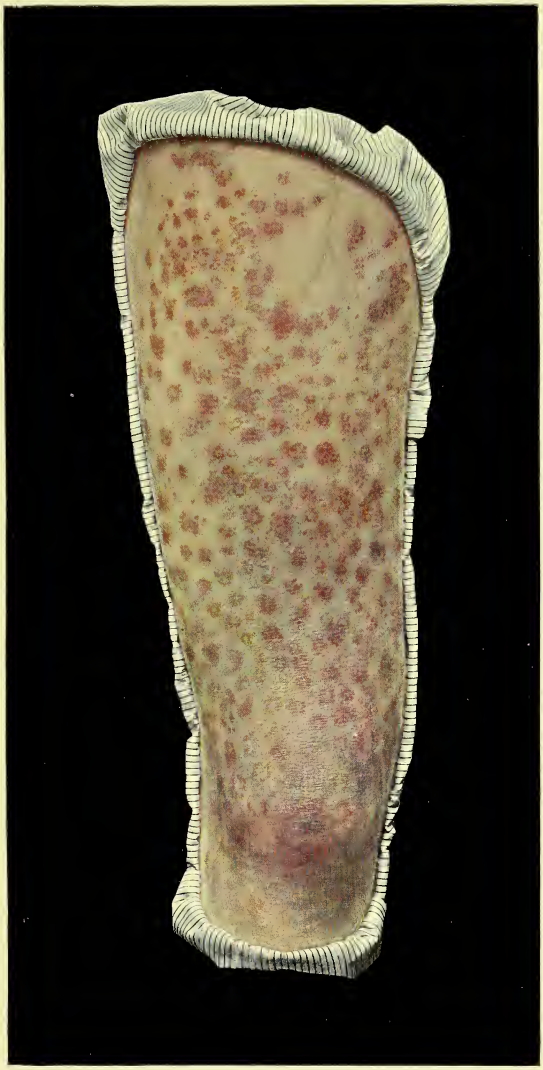
*Antipyrin* is one of the substances (like Migranin, Salipyrin, Pyramidon) which is frequently employed by the laity without a physician's prescription. Sometimes it is necessary, to confirm the diagnosis, to

administer to the patient the drug one has reason to suspect.

The **Prognosis** is usually favourable; only after generalized erythema with colossal desquamation—*e.g.*, from quinine, do repeated attacks of exhaustion occasionally occur, which may have a fatal termination.

The **Treatment** usually results from the diagnosis; but in bromide-eruptions the cessation of the drug frequently does not suffice, and the outgrowths must then be treated by superficial thermo-cauterization, scarification or the sharp spoon. The removal of the horny masses of arsenical keratosis may be expedited by the use of macerating salves or plasters.

Figs. 87, 89. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 88. Model in Lesser's Clinic in Berlin (Kolbow).
Fig. 90. Model in the Freiburg Clinic (Johnsen). An old medical man who, after every dose of Migranin, gets circumscribed urticarial eruptions on the buttocks, legs, shoulders and mucous membranes, which disappear after about a fortnight, leaving pigmentation.
Fig. 91. Model in Neumann's Clinic in Vienna (Dr. Henning). A hæmorrhagic eruption after copaiva.



No. 91. Toxicodermia ex usu balsami Copaivae.

# Scleroderma.

Plate L., Figs. 92, 93.

Two stages may, as a rule, be differentiated in the disease described as Scleroderma of adults, in contradistinction to the Scleroderma of infants. Doughy swellings appear in the skin, with or without subjective symptoms such as pains in the limbs and neuralgiæ. These swellings gradually merge into woodeny, hard indurations; the sclerosed parts may occasionally be elevated above, although usually they are on a level with, the surrounding skin, and sometimes they are depressed below it. During this process the integument soon becomes of a reddish, bluish-red or brownish tint; subsequently the colour is a glistening brown, or it may remain natural. A lilac ring, which shows up pretty clearly from the normal coloration, is often present at the points of transition between diseased and healthy skin.

*Universal* and *circumscribed* forms are differentiated according to the extent of the disease. To the former belongs the complete, diffuse scleroderma which usually runs a more rapid course and not infrequently recovers, as also symmetrical scleroderma of the scalp and extremities. The condition termed *Sclerodactylia* is the result of scleroderma of the hands, in which the skin of the fingers, as well as the subjacent tissues, undergoes marked atrophy, so that the hands become clawed.

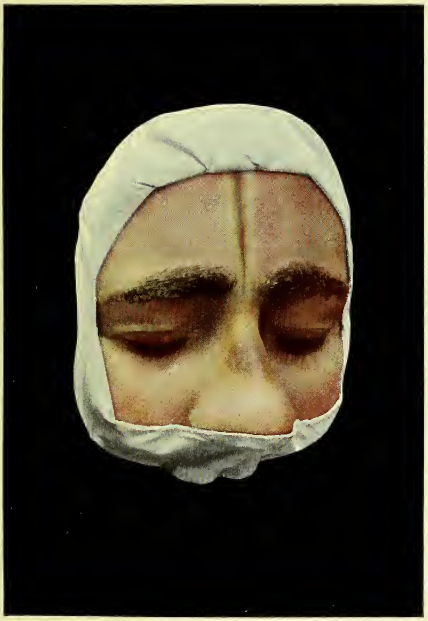
The course of the circumscribed form is generally more chronic. It occurs in bands or discs (Figs. 92, 93) and often shows nerve-distribution. The mucous membranes may be affected in the same way as the skin, especially in circumscribed cases. Scleroderma causes considerable disfigurement; when situated on the face the skin looks stiffened, the expression altered; and when the affection is unilateral, it is often associated with hemiatrophy, the underlying muscles and bones being involved. The movements of the fingers are greatly crippled from contraction of the skin and subcutaneous tissue, so that considerable fissures may result and prove the cause of much pain. The reduction of temperature over the parts involved is noteworthy; sensation is at first unaltered, but may be subsequently lowered, in proportion as the secretion of the cutaneous glands is diminished.

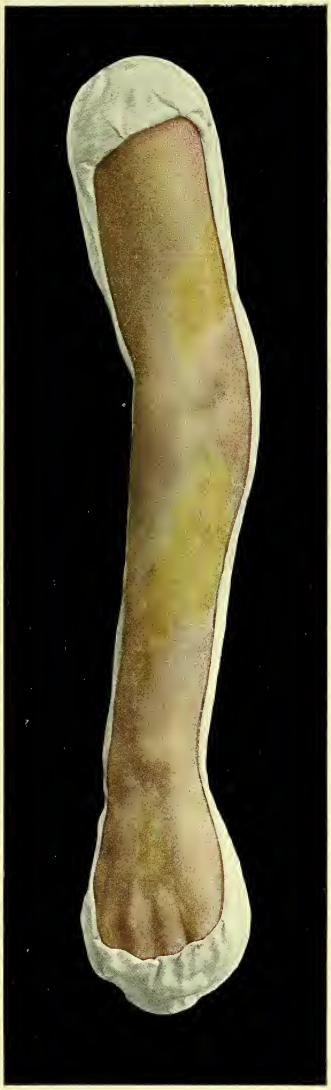
The course of scleroderma, apart from the universal form, is usually extremely chronic. The general condition of health depends upon the extent of the disease; in very extensive cases it is greatly impaired, and marked mental depression is usually added to the mechanical interference with various functions.

The **Etiology** is quite obscure. Some authors attribute it to disease of the nerves, others to changes in the bloodvessels or general nutritive disturbances.

The **Diagnosis** is easy in fully developed cases, especially when both stages are clearly manifested. Sclerodactylia may be mistaken for the local asphyxia of Raynaud's disease, but in the latter the skin is not adherent to the subjacent tissues nor is there any clawing of the hands.

The **Prognosis** must always be guarded.





No. 92. 93. Sclerodermia.

**Treatment** may relieve local pain, but cannot arrest the progress of the malady. In addition to general tonic diet, baths are chiefly used, such as Turkish, seaweed, or sand-baths. Massage, salicylic and resorcin salves, mercurial and salicylic plasters, vigorous active and passive movements or, finally, preparations of thyroid gland, and thiosinamine injections or plasters, may all be tried.

Figs. 92, 93. Models in Neisser's Clinic in Breslau (Kröner).

# Vitiligo.

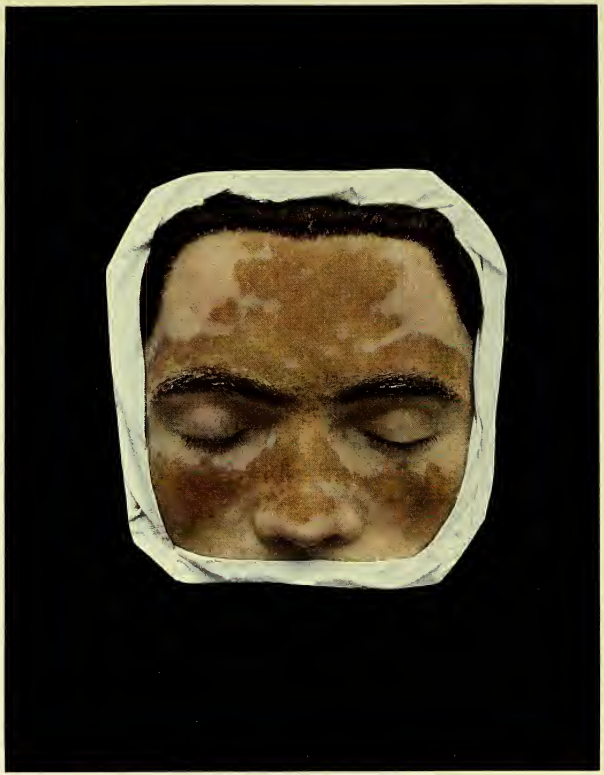
Plate LI., Fig. 94.

In addition to congenital absence of pigment, which is either universal (*Albinism*) or partial, and which is usually stationary, pigment may disappear from the skin without ascertainable cause (*Vitiligo*). The condition may be symmetrical, may follow the course of single nerves, or may have no determinate localization. It begins as circular, white spots, round the convex-spreading margin of which marked increase of pigmentation is recognisable, so that—strictly speaking—the condition ought to be described as a migration of colouring matter. There are no subjective symptoms or disturbances of sensation. When the disease is extensive, only scattered dark areas remain with concave outlines (Fig. 94). Serpiginous figures result from the coalescence of adjoining non-pigmented patches. The affection is generally incurable and slowly progresses, although the skin may assume a darker colour in summer; recovery may be said never to take place.

The **Etiology** is unknown, but sometimes general or nerve-disease is considered as its cause.

The **Diagnosis** is very easy in fully-developed cases. Syphilitic leucoderma may be differentiated

No. 94. Vitiligo.



No. 95. Chloasma.

from vitiligo by its localization, its accurately circular spots, and its less clearly defined margins.

No **Treatment** is of any avail. Such substances as mustard, cantharides, *etc.*, which cause pigmentation on normal skin have no effect on the diseased spots. If only a few pigmented areas remain, corrosive sublimate may be tried with caution, or peroxide of hydrogen, or resorcin-paste, to remove the pigmentation. If the disease is in a conspicuous place cosmetic measures may be employed.

Fig. 94. Model in Neisser's Clinic in Breslau (Kröner). On the abdomen there are two urticarial wheals.

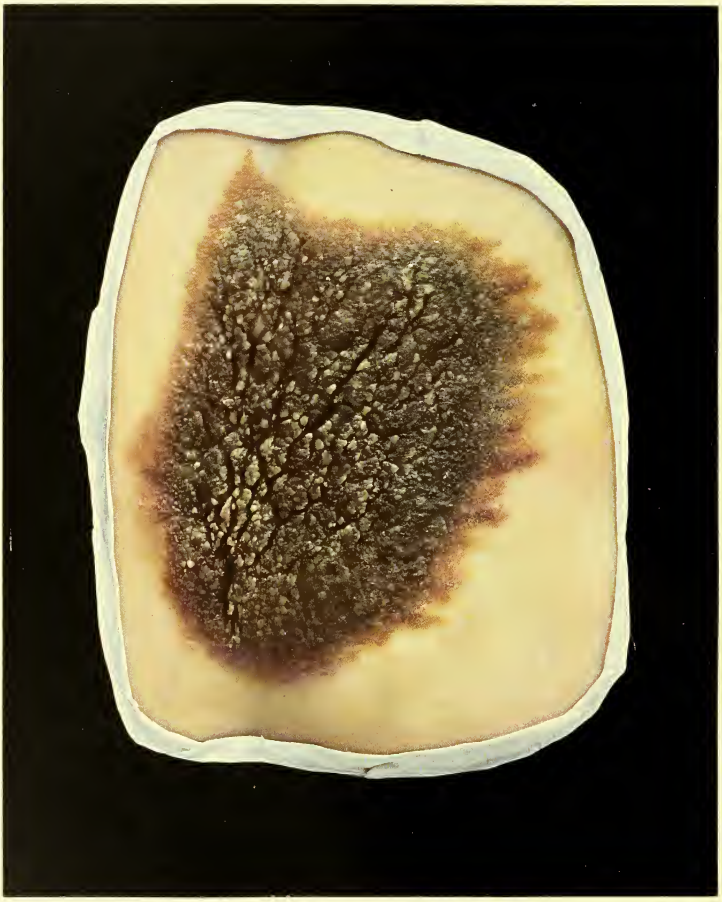
# Chloasma.

Plate LI., Fig. 95.

Whilst a large number of patchy or diffuse pigmentations of the skin are due to external causes, or result from antecedent skin diseases (*e.g.*, psoriasis, lichen, pediculosis), there are other pigmentary skin-affections which must be referred to diseases of internal origin. Pigmentation and bronzing constitute an important symptom of Addison's disease ; after the prolonged use of certain drugs, especially arsenic, pigmentation either in extensive sheets or in spots, occurs in predisposed persons; and the skin of patients suffering from various cachexiæ is very prone to abnormal discoloration.

Chloasma is a special form of hypertrophy of pigment which gives a characteristic, dark, mask-like tint to the skin, especially of the forehead, nose and cheeks. It may often be recognised as resulting from the coalescence of numerous small, brownish spots in the skin (Fig. 95). Pregnancy, and diseases of the uterus, may either give rise to the condition or may aggravate a congenital exaggeration of pigment. The colour disappears or diminishes after the removal of its cause. Remedies which provoke a vigorous desquamation of the deeper layers of epidermis act favourably, such as painting with 1 per cent. solution of corrosive sublimate in spirit, or rubbing in resorcin-paste till free scaling ensues—but the results are seldom permanent.

Fig. 95. Model in the Freiburg Clinic (Johnsen). The patient was in the ninth month of pregnancy.



No. 96. Naevus papillaris pigmentosus.

# Nævi. Verrucæ Seniles.

## Senile Warts.

Plates LII.-LIV., Figs. 96-99.

There exist in many persons benign growths of the skin which contain one or several of its component parts and exhibit wide variations of size and arrangement; some are present at birth but the majority develop later. Pigmentary nævi, among which freckles may be included, are the simplest of them, histologically. These are rounded or irregularly outlined spots of various sizes; they are sometimes unilateral, or they may be arranged along Voigt's lines.

In so-called 'soft nævi'—or moles—new cell formation is present in addition to the excess of pigment, while the hairs and cutaneous glands may also participate in the hypertrophy. The surface is often of warty, papillary structure (*nævi verrucosi seu papillomatosi*, Fig. 96). These warty nævi exhibit very widely different characters, some being flat prominences, others semiglobular growths; and they are especially worthy of note as being frequently the starting-point of malignant tumours in old age.

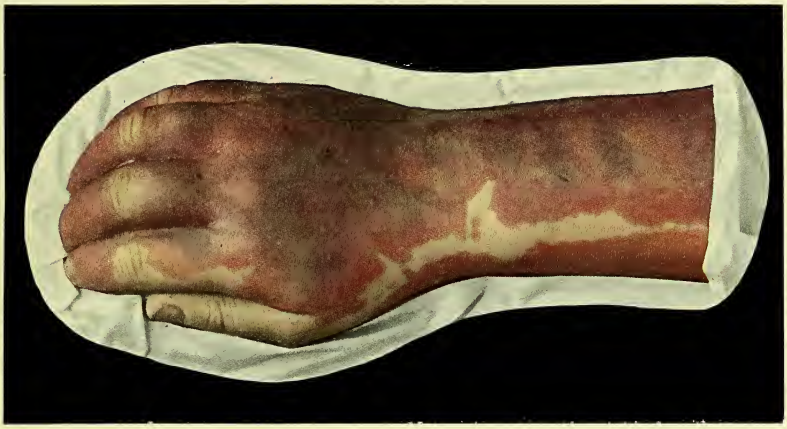
Vascular nævi (port-wine stains), Fig. 98, constitute another group; they are generally present at birth, and most frequently on the face; or they may be unilateral and involve a great proportion of the surface of the body. Various grades of new vascular forma-

tion may coexist, from hypertrophy of the surface capillaries to increase of the larger and deeper vessels, so that the skin is disfigured by irregular, warty or bossy masses. As time goes on these nævi may disappear, partially or entirely, or they may increase by spreading at the periphery.

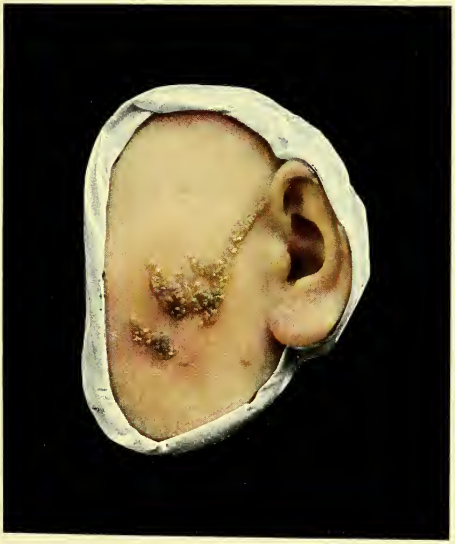
Nævi, in which hypertrophy of the cutaneous glands predominates, are called 'glandular nævi.' To this group belong the so-called *Adenomata sebacea*, which make their appearance—frequently in persons of weak intellect—at, or before, puberty. Hard, warty nævi are seldom present without the participation of pigment in excess.

The so-called 'systematized' or unilateral nævi are of special interest; they are composed of all the different components of the skin, and often appear to follow the course of nerves (*nerve-nævi* ?); but the influence of nerves on their existence does not permit of proof. They may spread in lines and patches, or their constitution by the coalescence of smaller, isolated nævi may be manifest (Fig. 97). Extension along the metameric lines is especially to be observed on the trunk.

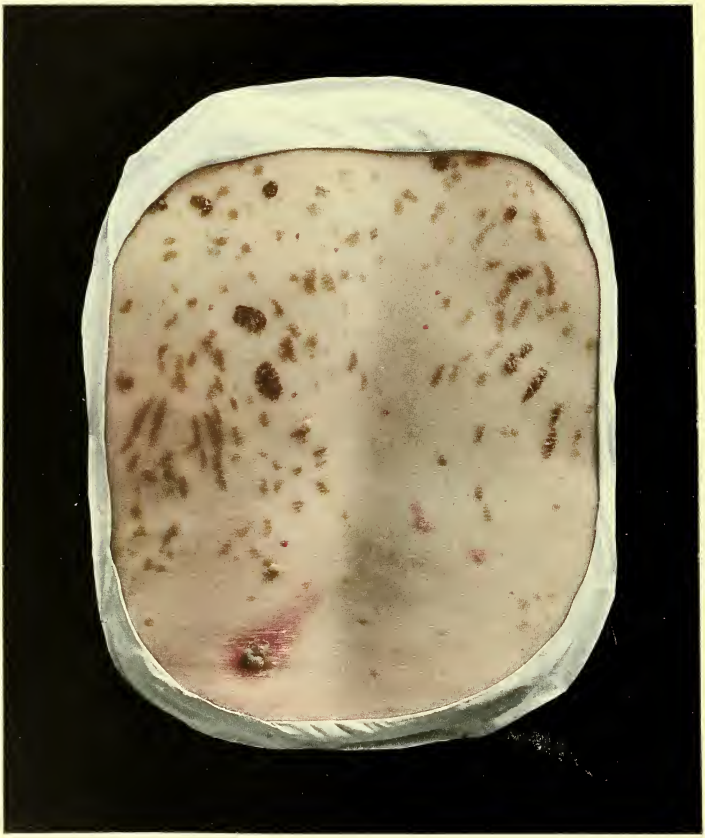
The so-called *senile seborrhœic warts* must be included among nævi; they usually arise after forty years of age, and in many people small angiomata (*Cavernomata senilia*) coexist. They are most frequently situated on the thorax and back, often very abundantly about the shoulders. Sometimes they show a band-like arrangement (Fig. 99). The lesions at first have a fatty feel and are of light-brown colour; afterwards they become gray or brownish-black, scaly and slightly granular on the surface. In size they vary from a lentil to a bean. The entire, flat growth may be removed by scratching, when the papillary layer—which bleeds easily—is exposed. Although



No. 97. Naevus teleangiectodes.



No. 98. Naevus linearis.



No. 99. Verrucae seniles; Cavernomata senilia.

transformation into malignant growths is very rare, it occasionally takes place.

The **Diagnosis** of nævi ought seldom to be a matter of difficulty. Their history, congenital nature, early development and subsequent stationary character, are easy to establish.

The **Prognosis** is favourable, except in the very exceptional cases in which malignant degeneration occurs. Nævi are chiefly of importance on account of the disfigurement they cause.

**Treatment** must in most cases be surgical. Small pigmentary nævi are best removed by dabbing with a 1 per cent. solution of sublimate in spirit, till irritation ensues. In large, white moles electrolysis yields excellent cosmetic results. Vascular nævi may be caused to wither by superficial galvano-caustic needling, or by Finsen's light-treatment. Senile warts are best removed by scraping with the sharp spoon, the base being then touched with lunar caustic. There is, as a rule, no successful method of dealing with large nævi.

Fig. 96. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 97. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 98. Model in the Freiburg Clinic (Johnsen). A girl, seventeen years of age, with an enormous *nævus flammeus* covering nearly the entire half of the body, and leaving but little healthy skin.
Fig. 99. Model in Neisser's Clinic in Breslau (Kröner). On the lower part of the back is a carcinomatous tumour in course of development.

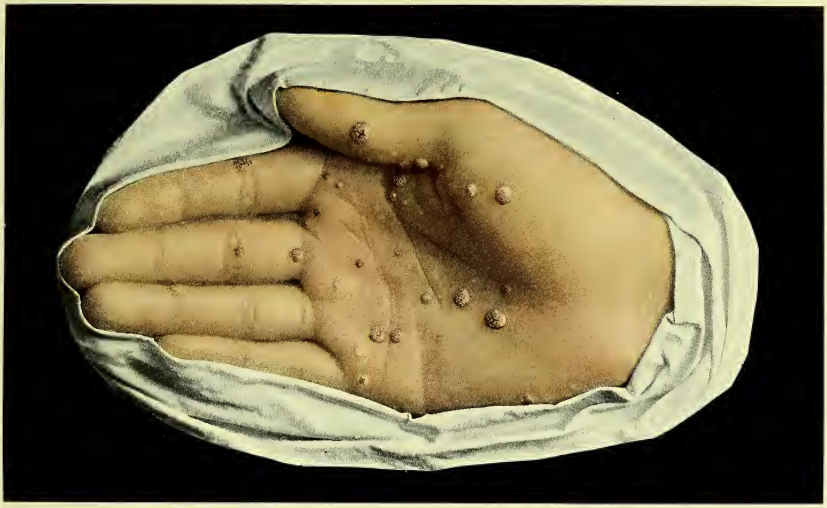
# Verrucæ Vulgares.

## Warts.

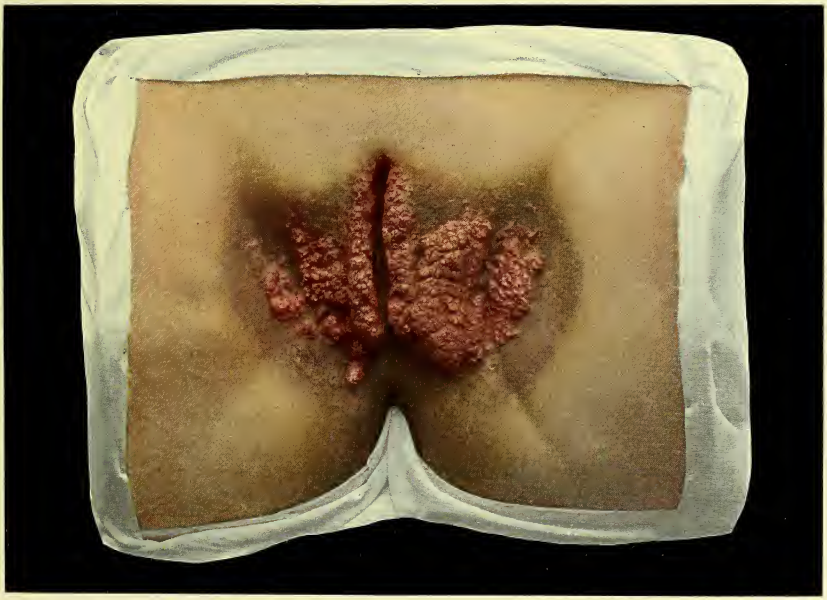
Plate LV., Fig. 100.

Common warts occur most frequently in young persons, less so in those of middle age, and chiefly on the hands, feet and scalp. They are generally flat, circular or polygonal in outline, and become split up on their surface as cornification increases, thus assuming a dirty-grayish colour; finally, they become of very firm consistence (Fig. 100). Strict differentiation of flat from hard warts appears to us unjustifiable. Their size is at first scarcely that of a lentil, but as they grow, they may become as large as a pea or bean. Often a number of recent warts are grouped round old ones. Successful inoculation-experiments have proved that warts are undoubtedly of infective origin, but they have an unusually prolonged period of incubation which may last for months. Subjective symptoms are present only when they are situate on the soles, where outward growth is impossible and the wart remains in the thickness of the skin, or when they are present along the sides of the nails and painful fissures occur.

The **Diagnosis** of common warts is generally easy, except when they are situate on the palms, and their secondary infection by organisms may then pretty closely simulate syphilides. Lichen planus is



No. 100. Verrucae vulgares.



No. 101. Papillomata.

of quite distinct colour, generally occupies different parts of the body, and itches. Arsenical keratosis and ichthyosis spread diffusely along the skin-surface, while 'post-mortem warts' have always an inflamed border.

The **Prognosis** is favourable.

**Treatment.**—The internal administration of arsenic is often employed, and may, after a long time, prove efficacious. In almost all cases, however, the use of external means is necessary, and various caustics (*e.g.*, trichloracetic acid, fuming nitric acid, acetic acid) may be used. Electrolysis may succeed, or warts may be removed surgically under ether-spray or chloride of ethyl. It is often stated—but the statement is of dubious veracity—that if a central wart is removed, those round about disappear. Quite recently very rapid cures by light-treatment have been reported.

Fig. 100. Model in Lesser's Clinic in Berlin (Kolbow).

# Papillomata.

## Condylomata Acuminata.

Plate LV., Fig. 101.

Papillomata are a form of benign growth which occur chiefly on the skin and mucous membrane of the genitals, and spread thence to the neighbouring parts of the thighs and over the perinæum to the anus. Cauliflower-like tumours result, which are made up of much-hypertrophied and divided papillæ, covered by thickened epidermis, and these subsequently coalesce (Fig. 101). Similar lesions sometimes affect the auditory meati, the nose and the lips. The surface of most papillomata is at first like mucous membrane, but a sort of cornification may subsequently ensue. A particularly offensive secretion is present between the separate, macerated papillæ, which make up the larger growths. As a rule there are no inflammatory signs about the surrounding parts; tumours as large as the fist may form by hypertrophy and extension, in cases of old standing.

Papillomata are usually provoked by the irritation of gonorrhœal discharge, but cases pretty often occur in which there is no gonorrhœa. The method of extension in crops strongly suggests the idea of an infective cause, but nothing is definitely known on the point.

The **Diagnosis** of papillomata is easily made from their typical appearance, sharp demarcation, and distribution. The use of the term *condylomata* gives rise to some possibility of confusion with syphilitic papules; it had better be replaced by the name in use here.

The **Prognosis** is favourable.

Dryness and cleanliness of the genitals in both sexes, especially in persons suffering from gonorrhœa, must be observed as means of prophylaxis.

**Treatment** first consists in removing the cause —*e.g.*, gonorrhœa, balanitis, vulvitis, etc. Large papillomata may be snipped off with scissors. Numerous small growths are best removed with the sharp spoon, and their bases subsequently touched with nitrate of silver or liquor ferri sesquichloridi. Papillomata often disappear after simply keeping the parts dry and using powders, such as oxide of zinc or boric acid. Certain well-known caustics are frequently employed—*e.g.*, equal parts of caustic lead, savin-tops and alum (Gerhardt), 10 per cent. solution of resorcin, or formalin, or chromic acid. For very obstinate, horny papillomata, the application of thick resorcin-jelly or salicylic acid plaster-mull may be recommended.

Fig. 101. Model in the Freiburg Clinic (Johnsen). A maid-servant, nineteen years old. No gonorrhœa detected.

# Fibromata Mollusca.

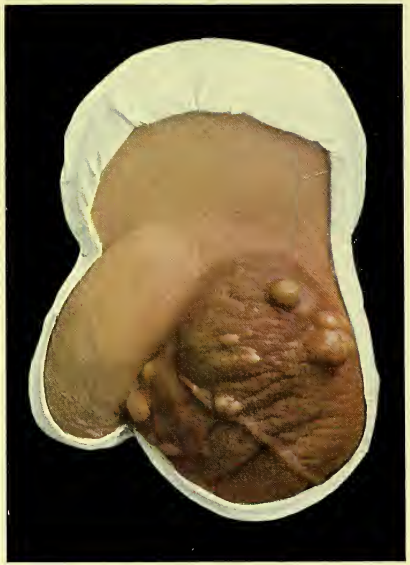
## Molluscum Fibrosum.

Plate LVI., Fig. 102.

Single, isolated fibromata of the skin are comparatively seldom observed. Multiple, soft fibromata arising from nerve-sheaths (*neuro-fibromata*), are much more frequent and may be congenital, or on a congenital basis. They usually occur in extremely large numbers, and are of very various size; sometimes they lie flat in the thickness of the skin, sometimes they are pedunculated, or may be enclosed in folds of the integument, resembling boils (Fig. 102). After the disappearance of their contents an empty pouch of skin remains. Small, or comparatively large nævi, are often present in greater or less number along with the fibromata, which latter appear bluish and somewhat translucent owing to their deep situation in the skin. The skin over the growths is either normal, or may present some dilatation of its bloodvessels or ducts. The tumours may increase to an enormous size and, ultimately, ulcerate on the surface. Severe pain must be mentioned as one of the subjective symptoms. The occasional occurrence of sarcomatous degeneration is also worthy of note. A very marked degree of disfigurement may be caused by the disease.

The **Diagnosis** can hardly present any difficulties.

No. 102. Fibromata mollusca.



No. 103. Atheroma multiplex (Cystes sebaceae).

The **Prognosis** is favourable, apart from the possible occurrence of malignant degeneration of the growths ; but spontaneous absorption and disappearance of the disfigurement and pain are hardly to be anticipated.

**Treatment** is purely surgical, and ought to be limited to the removal of the largest and most annoying tumours.

Fig. 102. Model in Lassar's Clinic in Berlin (Kasten).

# Atheroma Multiplex.

## Cystes Sebaceæ.

Plate LVI., Fig. 103.

Sebaceous cysts usually occur in persons of middle age on the scalp, less frequently on the face, or about the genitals (Fig. 103); they result from hypertrophy of the sebaceous glands. The suppuration of their contents and cystic degeneration often cause the formation of bossy tumours as large as a pea or, rarely, as a fist. They usually are multiple, and the opening of a sebaceous duct can often be recognised at their summit, from which inspissated sebum can be expressed. The growths are surrounded by a sheath—a pretty-thick membrane of connective tissue — which can generally be easily and completely shelled or dissected out. Their rupture and spontaneous cure by suppuration very seldom take place, and their malignant degeneration is also very rare.

The **Diagnosis** is always easy, and may be made upon the seat, the painlessness, the shape and the contents of the growths.

The **Prognosis** is favourable.

**Treatment** must be surgical, and the complete removal of the sheath is of special importance to prevent the possibility of recurrence.

Fig. 103. Model in Neisser's Clinic in Breslau (Kröner).

Note.—The retention of the old term 'Atheroma' is misleading and regrettable.—J. J. P.

# Mollusca Contagiosa.

Plate LVII., Fig. 104.

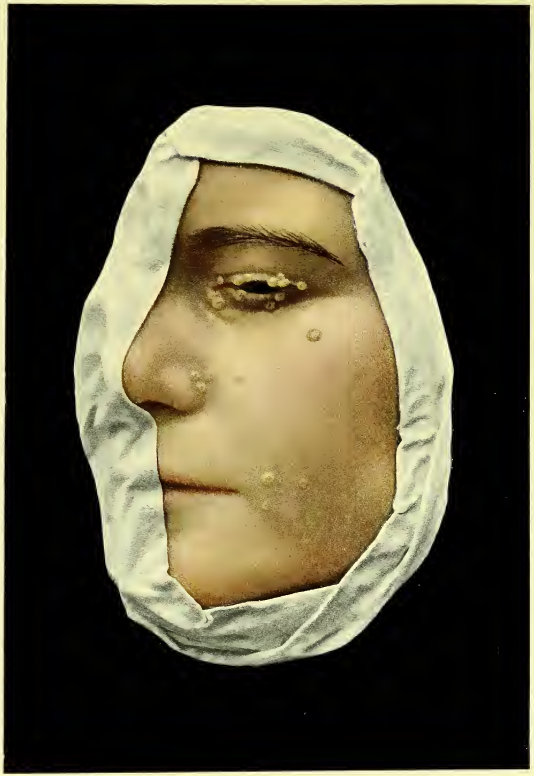
Mollusca contagiosa are small, semi-globular, nodular growths which appear most frequently about the genitals in adults, but are commoner in children, and generally affect the face (Fig. 104) and scalp. They are of pale-reddish, somewhat translucent tint, and gradually increase to the size of a lentil or pea, but occasionally may be bigger. In their centre there is a depression, sharply defined by a circular line, inside which the skin is of finely-granular and dry appearance. A single molluscum is of rare occurrence; more frequently there is a crop of smaller and more recent lesions round an older one, while sometimes they are arranged in lines corresponding to scratch-marks. On firm lateral pressure the central portion can be completely squeezed out, and slight bleeding occurs; the plug thus evacuated is slightly hyaline in appearance, and numerous, refractive bodies (*molluscum bodies*) can be observed in it under the microscope. After removal of its contents the nodule collapses. Mollusca contagiosa grow extremely slowly, and remain unchanged for a long time. The cause of these undoubtedly infective growths is not yet ascertained, inoculation-experiments having hitherto proved futile; some authors believe that they are due to minute organisms of the class of protozoa.

The **Diagnosis** can easily be made from their central depression. The microscopical demonstration of 'molluscum-bodies' in the plug they contain, decides the point in doubtful cases.

The **Prognosis** is favourable.

The best **Treatment** consists of squeezing out their contents with a comedo-extractor or the fingers. Large mollusca may be surgically removed.

Fig. 104. Model in Lesser's Clinic in Berlin (Kolbow).



No. 104. Mollusca contagiosa.

No. 105. Keloid.

# Keloid.

Plate LVII., Fig. 105.

A distinction is drawn between true and false keloids according to their origin from pre-existing scars or from normal skin; but one can never exclude the possibility of the latter form arising from some very superficial injury. Keloids are flat, circumscribed tumours of ribbon-like or lumpy appearance. Outgrowths resembling promontories extend from their margins into the surrounding healthy skin, into which they gradually merge. The surface of a keloid is smooth, generally like a scar, and often is traversed by fine bloodvessels, so that it becomes of reddish tint, especially at the margin. Keloids may cause trouble by pain or great tenderness on pressure, as well as some disfigurement. Their cause is still unknown; racial proclivity (*e.g.*, in negroes) is often advocated, but some form of infectivity cannot be excluded. Their commonest seat is the præsternal region (Fig. 105), but they may occur on the face or any other part of the body, especially so-called 'scar-keloids.'

The **Diagnosis** may be based upon the localization, the pain and the peculiar knobby or band-like form of the tumours.

The **Prognosis** is unfavourable, as recurrences almost always take place after operative removal,

while spontaneous disappearance is of extremely rare occurrence.

**Treatment** is correspondingly devoid of result. Injections of thiosinamin, the application of 10 per cent. thiosinamin-plaster, and electrolysis, may be tried; or, finally, free incision with subsequent skin-grafting.

Fig. 105. Model in Kaposi's Clinic in Vienna (Dr. Henning).

# Xanthoma.

Plate LVIII., Fig. 106.

Xanthoma is a benign new-growth of the skin generally dependent upon some congenital condition, and characterized by its peculiar sulphur, or reddish-yellow, colour. It occurs either isolated (*Xanthoma circumscriptum*), especially on the eyelids (Fig. 106), or as a more extensive eruption (*Xanthoma disseminatum planum vel tuberosum*). In the former, there are present on the eyelids flat-topped, more or less raised, painless spots, or deposits 'let into' the skin, of a marked yellow colour; these cause no symptoms and are strictly localized in the situation mentioned or in its immediate vicinity.

The disseminated form may occur either as flat outgrowths in the flexures of the joints and palms, or as hard, tuberous, often lobulated new growths, of very considerable size and most frequently present on the extensor surfaces of the extremities. They sometimes are of reddish or purplish, as well as of yellow, tint. The tumours of Xanthoma are almost always symmetrical in arrangement, and develop slowly till they attain a certain size. They hardly ever disappear spontaneously. It is noteworthy that changes in the liver (jaundice) and xanthoma in the tissues of other internal organs have been observed, especially in connection with the disseminated form.

Whether or not *Xanthoma diabeticorum* is to be

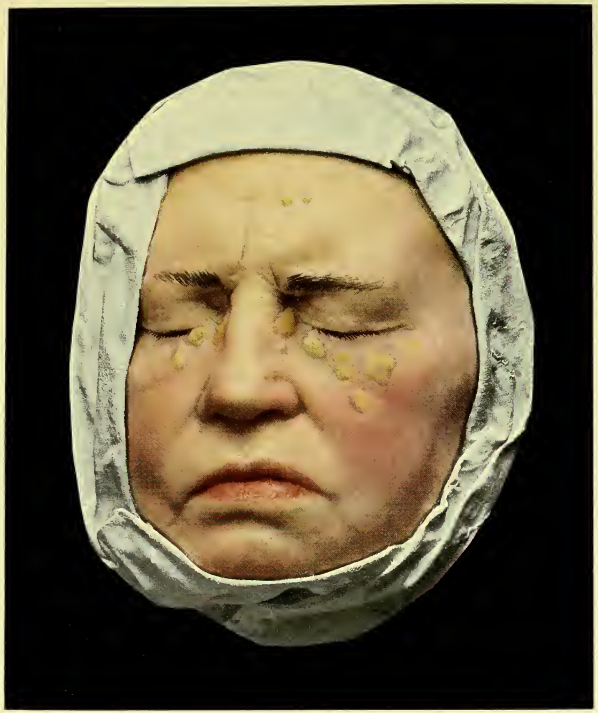
considered a true form of xanthoma is, as yet, not definitely settled. It arises as an acute condition in the course of glycosuria, and, as a rule, spontaneously disappears after a more or less prolonged period. It is also not certain to what degree the occurrence of xanthoma is referable to disease of internal organs, especially of the liver.

The **Diagnosis** is easily made from the yellow colour and the localization of the lesions.

The **Prognosis** is favourable.

**Treatment** can only be surgical, but electrolysis may be tried.

Fig. 106. Model in Lesser's Clinic in Berlin (Kolbow).



No. 106. Xanthoma.

No. 107. Xeroderma pigmentosum.

# Xeroderma Pigmentosum.

Plate LVIII., Fig. 107.

Xeroderma pigmentosum is a very rare disease, which generally runs in families and shows itself in early childhood. Under the influence of sunlight an erythematous or eczematous dermatitis appears on the face, arms and legs, upon which, as a basis, numerous pigment-spots of the most variable size develop, along with telangiectases and warty growths; and these finally leave white, atrophic, pitted spots (Fig. 107). The atrophy may attain considerable dimensions and the pigmentary spots become very numerous and extensive. The special point of importance about the disease is the fact that even in early youth, or often later, malignant growths (carcinoma and sarcoma) develop from the pigment-spots and lead to secondary growths in other organs.

The **Diagnosis** is difficult at first, but is subsequently easy.

The **Prognosis** is absolutely unfavourable, but the malady may last for years.

**Treatment** consists, in the first instance, of attempting to hinder the progress of the disease by preventing exposure to the active chemical rays of light—*e.g.*, by yellow veils, coloured pastes, etc. The tumours must be removed by surgical means, but relapses and metastases seldom fail to occur.

Fig. 107. Model in Saint Louis Hospital in Paris (Baretta). Quinquaud's case.

# Paget's Disease.

PLATE LIX., FIG. 108.

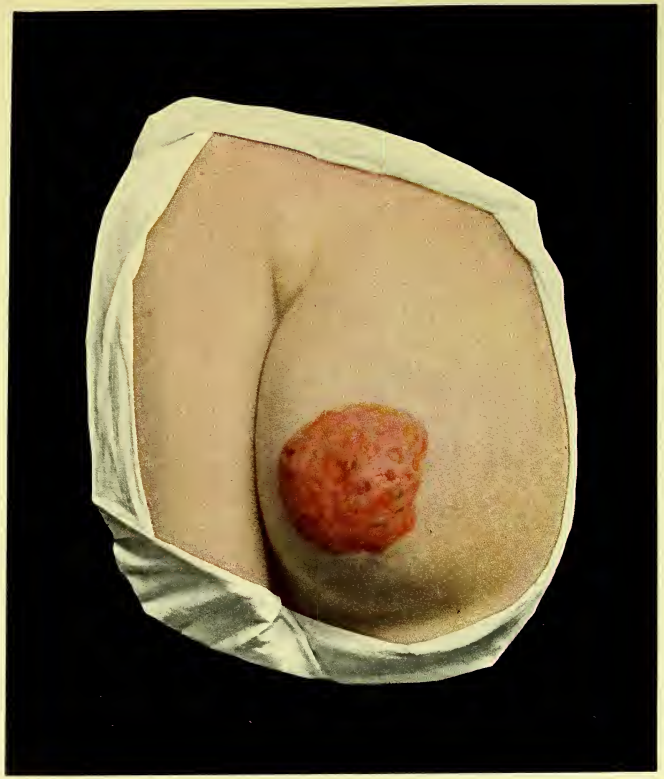
Paget's disease of the breast usually begins as an obstinate, moist, eczematous condition on and around the nipple, in women about the climacteric. The disease very seldom occurs in other parts of the body, *e.g.*, the anal region. The weeping spot is at first small, excoriated, covered in places with papillary, horny growths, and has a very sharply-defined line of demarcation. After some time the affected area becomes flat, with parchment-like induration, and the disease may attain considerable dimensions, while regressive changes, with shrinkage and retraction of the nipple, result (Fig. 108). Ultimately carcinoma of the neighbouring lymphatic glands, or of the mamma, usually complicates the process.

The **Diagnosis** of Paget's disease from chronic eczema must first be established. In eczema the margin is not so sharply defined; subsequently the long duration of the malady, the parchment-like hardness and, in doubtful cases, the microscopic examination of a portion of excised tissue, will decide the diagnosis.

The **Prognosis** is invariably dubious.

The **Treatment** is purely surgical and consists in removal of the entire breast.

Fig. 108. Model in Saint Louis Hospital in Paris (Baretta). Vidal's case.



No. 108. Morbus Paget.

No. 109. Ulcus rodens (Epithelioma).

# Ulcus Rodens.

## Rodent Ulcer.

Plate LIX., Fig. 109.

Rodent ulcer is the commonest and most interesting form of primary carcinoma of the skin and occurs chiefly in persons of middle or advanced age. Originating as a small, hard nodule of normal, or slightly reddish, colour, it spreads at the periphery and breaks down in the centre so as, finally, to form a flat ulcer, with hardened base and margin, which is generally round or kidney-shaped in outline. The border is slightly raised, partially undermined, and, as a rule, renders the nature of the new-growth manifest. The ulcer is faintly granular on the surface, and red or livid in colour. The amount of secretion from it is small and soon dries up to form adherent crusts. Healing in the centre occurs pretty frequently; but exceptionally, in cases of long standing, the ulceration extends to the deeper parts. Rodent ulcer is regarded as comparatively benign on this account, and also because involvement of the corresponding lymphatic glands seldom or never occurs. A transformation into malignant carcinoma does, however, sometimes take place. The face is the seat of predilection, especially the nose (Fig. 109), and the eyelids; the genital region may be attacked but other parts of the body are very rarely affected. Rodent ulcer has occasionally been observed to originate from seborrhœic warts.

The **Diagnosis** must be founded upon the localization, the age of the patient, the hardness of the base and margin, and the very slow spread of the disease; and it is usually easily made. Sometimes the differential diagnosis from syphilis is difficult, especially when the lesion spreads at the edge and heals in the centre, as frequently takes place also in that disease. In dubious cases the result of microscopical examination of an excised portion, or the failure of antispecific remedies, along with the absence of other syphilitic phenomena, will decide the matter.

The **Prognosis** is favourable in very localized cases in the early stages, but afterwards malignancy may set in.

**Treatment.**—In view of the comparatively benign character of the disease at its beginning scraping, thermo-cauterization, or the use of various caustics are often successful. But such cases must always be kept under close observation, and if any extension of the disease occur, only energetic surgical procedures are of avail. The efficacy of the internal or subcutaneous administration of arsenic is very doubtful.

Fig. 109. Model in Neisser's Clinic in Breslau (Kröner).

# Sarcoma Cutis.

## Sarcoma idiopathicum multiplex hæmorrhagicum.

Plates LX., LXI., Figs. 110, 111.

Sarcoma occurs upon the skin either secondarily to growths in internal organs or primarily; among the latter are the very malignant, pigmentary sarcomata arising from irritated nævi, which usually soon give rise to secondary growths elsewhere. Non-pigmented forms are also observed, in which isolated or disseminated, firm nodules, of normal or red and livid colour, sometimes occupy a great part of the integument (Fig. 110). Their course is slow or rapid according to their degree of malignancy, and leads sooner or later to secondary growths in internal organs and lymphatic glands. The larger tumours may ulcerate.

The disease described by Kaposi as *idiopathic multiple hæmorrhagic pigmentary sarcoma* merits special attention. It first appears on the extremities in the form of bright-red lumps, which soon become bluish from hæmorrhage into them. With these growths a superficial sarcomatosis of the skin is soon associated; this is accompanied by considerable pain, and the recent tumours assume all the characters of the original ones, including their blue and livid tint (Fig. 111). Further spread to internal organs takes place comparatively seldom, in contrast with other rapidly progressive skin-sarcomata; while spontaneous

disappearance of separate nodules, with pigmentation and atrophy, not infrequently happens. Death, as a rule, occurs only after a very prolonged period.

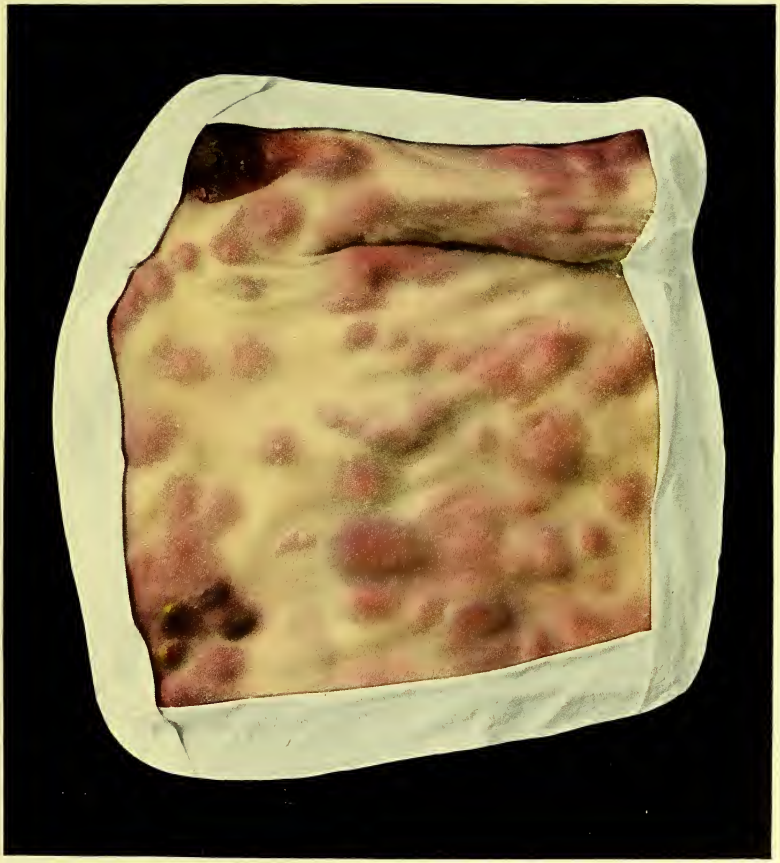
The **Etiology** of sarcoma is still unrecognised, but many facts point to the possibility of its being an infective process.

The **Diagnosis** of isolated pigmentary sarcomata is not particularly difficult when they develop from nævi. The recognition of non-pigmented sarcomata is much harder ; they may be mistaken for granulation-tumours, syphilis, tuberculosis, actinomycosis, or mycosis fungoides. A microscopical examination may be necessary to settle the matter, after the failure of antisyphilitic treatment and of reaction to tuberculin have been verified. Multiple, idiopathic, hæmorrhagic sarcoma may be recognised with certainty by its localization and course.

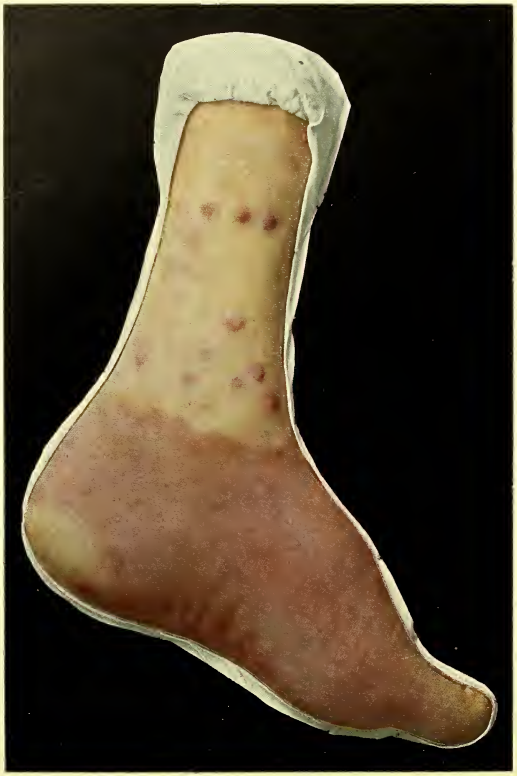
The **Prognosis,** except in the last-mentioned form, is utterly bad, as even when early ablation is carried out, local relapses and secondary growths almost invariably occur, especially in pigmented cases.

**Treatment.**—Injections of arsenic may first be mentioned as worthy of trial, but removal with the knife must be applied to pigmentary nævi, as soon as they show signs of malignancy.

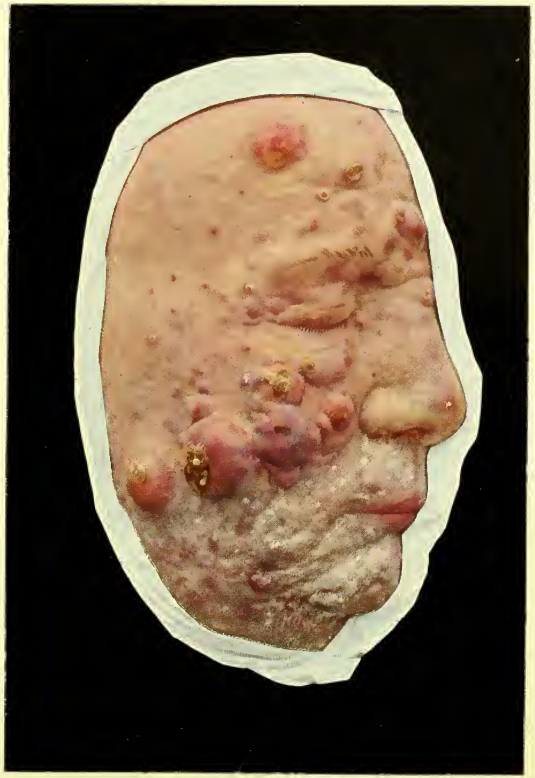
Fig. 111. Model in Neisser's Clinic in Breslau (Kröner).



No. 110. Sarcomatosis cutis.



No. 111. Sarcoma idiopathicum multiplex haemorrhagicum.



No. 112. Mycosis fungoides.

# Mycosis Fungoides.

Plate LXI., Fig. 112.

The first stage of Mycosis (or Granuloma) fungoides is characterized by the appearance of violently-itchy, very chronic patches on the skin, which resemble eczema or psoriasis, but resist all treatment suitable for these diseases. After the inflammatory, infiltrated patches have lasted for years, tomato-like tumours develop either from them or rise abruptly from healthy skin; they are of bluish or reddish-brown colour and sometimes ulcerate on the surface (Fig. 112). After a prolonged duration of the malady death ensues from marasmus, often with internal secondary deposits. In very rare cases the pre-mycotic stage is absent.

The **Etiology** is unknown. The tumours present anatomical characters somewhat similar to those of sarcoma.

The **Diagnosis** is extremely difficult in the earlier stages, and can only be established by the extraordinary resistance of the patches to ordinary therapeutic measures, by the violent itching, and by the prolonged duration of the disease. In the second stage the characteristic tumours render the diagnosis a matter of no great difficulty.

The **Prognosis** is very unfavourable.

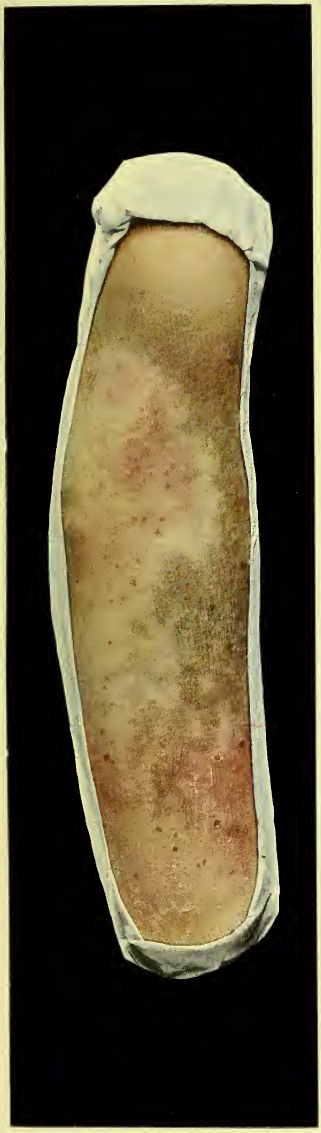
**Treatment.**—Cures by arsenic have been reported, but the remedy is utterly unreliable.

Fig. 112. Model in Saint Louis Hospital in Paris (Baretta). Hallopeau's case.

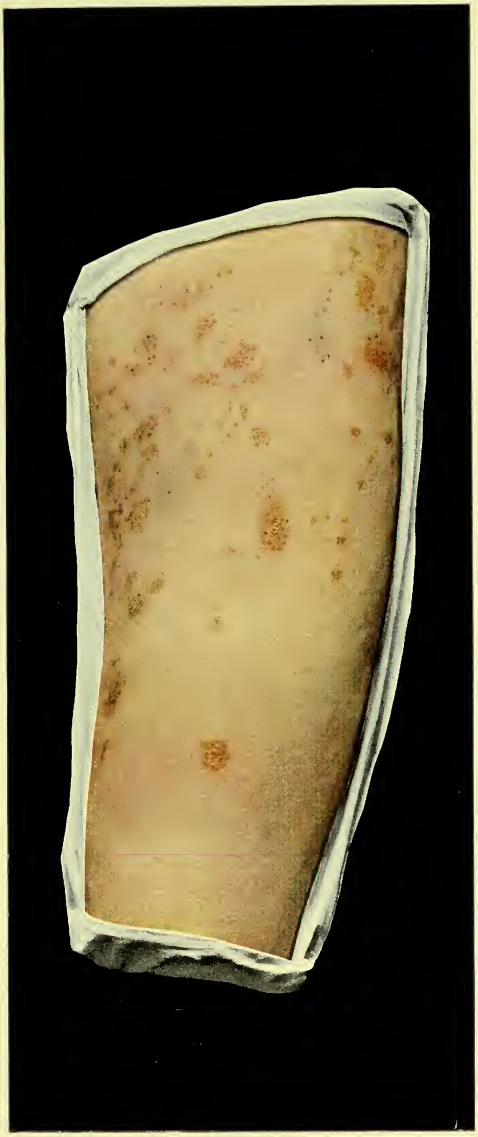
# Eczema.

PLATES LXII.-LXVII., FIGS. 113-122.

The name Eczema connotes the most frequent superficial disease of the skin, in which all the different degrees of its inflammation occur either together or separately, accompanied by severe itching. According to the intensity of the exudative process, which takes place chiefly in the epithelium—but which may affect the deeper layers in cases of longer standing or greater severity—a distinction is drawn between the *erythematous* phase, characterized by mere redness and diffuse swelling, the *papular* phase, in which separate, localized collections of exudation occur (Fig. 113), and the *vesicular* phase, in which the upper epidermic layers are elevated by exudation so as to form small blebs. In the latter phase the contents of the vesicles may become cloudy from the migration of leucocytes, constituting *pustular* eczema. If the covering of the vesicles is removed either by spontaneous rupture or by mechanical injury, and large quantities of serous fluid are exuded, the condition becomes a weeping eczema (*E. madidans vel rubrum*), the latter term being chiefly employed when large sheets of the rete Malpighii are exposed (Fig. 117). If the amount of discharge is slight, the serum dries up to form crusts (*E. crustosum vel impetiginosum*); after this phase passes away, if no recrudescences take place, the epidermis of the part becomes reintegrated, but the persistence of inflammation of the still infiltrated



No. 113. Eczema acutum cum pigmentatione.



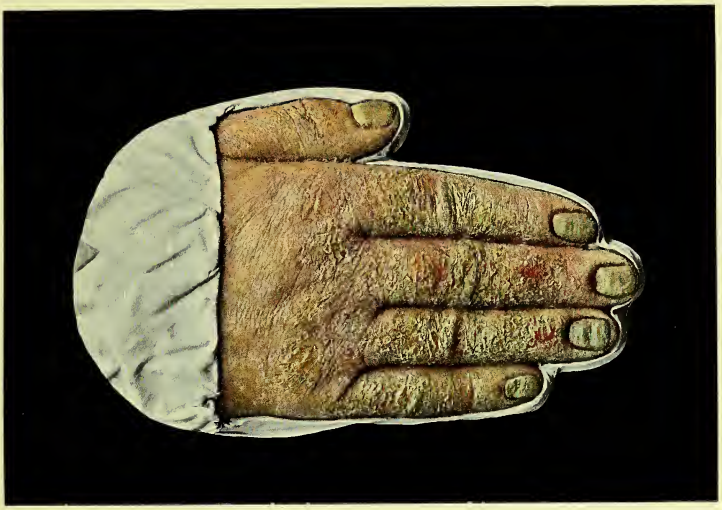
No. 114. Eczema folliculare.

skin gives it a red, scaly appearance (*E. squamosum*, Fig. 115). Relapses easily arise in this phase from mechanical or other irritants, and discharge recurs, so that the different stages of eczema are frequently observed simultaneously in the same patient, thus giving to the disease its polymorphous character. Owing to repeated relapses, final cure is greatly retarded and the process shows a marked tendency to last for a long time, during which exacerbations constantly recur (*E. chronicum*). Squamous eczema, the last stage of the disease, may also arise directly from the papular or vesicular stage, so that it is generally looked upon as its terminal phase. But, after apparently complete recovery, a loss of resisting power in the skin to trivial mechanical and chemical irritants persists, so that relapses occur as a rule, even after a cure has been seemingly effected.

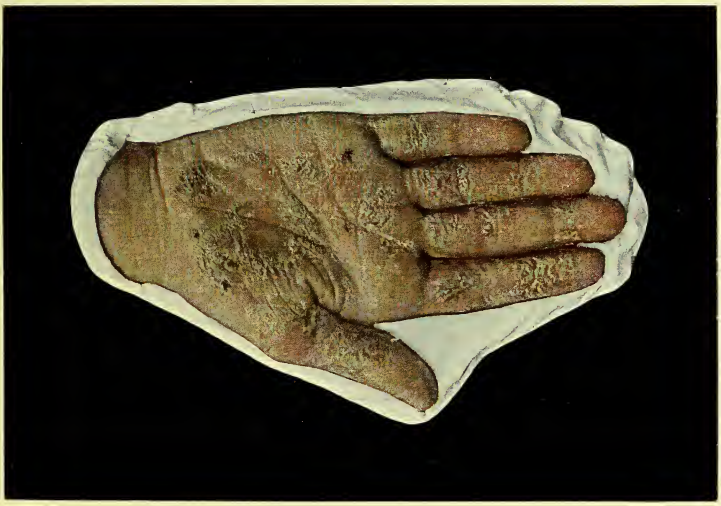
The **Etiology** of eczema is not clearly understood. Not only are external irritants considered as responsible for its occurrence, but an internal predisposition is also evoked; this latter, however, must be regarded as a cooperating, not as a direct causal, factor. Thus, persons who suffer from disturbances of nutrition, anæmia, chlorosis, digestive disorders (especially in young children), or from constitutional, or chronic infective diseases such as diabetes, nephritis or scrofula, become victims to eczema more readily than those whose general and cutaneous nutrition are normal. Irritants of mechanical or chemical character, especially when the skin is exposed to them frequently or for prolonged periods, are universally recognised as direct excitants of eczema; but even in such cases, a certain predisposition is necessary for the development of the disease. It is admittedly often impossible to detect the irritant at work, but it seems more than probable

that a considerable number of the materials which come in contact with the skin in daily life are capable of causing eczema in predisposed subjects; for instance, it is only some years since the primula obconica was discovered to be the cause of very intense and obstinate eczema. Other well-known causes are certain chemicals —*e.g.*, iodoform, corrosive sublimate, carbolic acid, arnica, ethereal oils, turpentine, certain soaps—or even ordinary water if applied for a prolonged period, as in poultices. Chemical light-rays may act similarly. It is also well known that cement, quicklime, and flour may provoke the disease, but chemical irritation must in such cases co-operate with mechanical causes, for the latter may alone be exciters of eczema, as for example, in long-standing cases of scabies which present the objective characters of eczema in its most typical forms. Recent observations have established the fact that the usual pyogenetic staphylococci play a certain part in the development of eczema.

The localization and nature of the causal factors have a marked influence on the clinical character and course of the various forms of eczema. When localized, as it so frequently is, on the face different types are observed; that known as *Crusta lactea* in children (Fig. 120) occurs chiefly on the cheeks, forehead and ears, but also on the hairy scalp, in which grayish yellow and brown or even bloody scabs are present, along with numerous, weeping, scratched surfaces. Swelling of the neighbouring lymphatic glands is usually present. Acute eczema of the face is common in adults and presents a certain resemblance to erysipelas, owing to the amount of swelling, itching, œdema and vesication; it may even cause a certain degree of baldness by extension to the scalp, but such baldness is generally only temporary. A tiresome form of impetiginous eczema of the neck and scalp



No. 115. Eczema chronicum squamosum.



No. 116. Eczema chronicum volae manus corneum.

often attacks young people, and discrete lesions, exactly resembling impetigo-pustules, simultaneously appear on the face and hands, as the result of the presence of pediculi capitis; indeed, it is highly probable that the great majority of cases of so-called impetigo are referable to pediculi, and that the extremely infective character of the contents of these pustules is alone responsible for the spread of the disease. In such cases marked swelling of lymphatic glands is usually present, so that they are often considered as of scrofulous nature. As the result of neglect, the condition of gluing and matting together of the hair—known as *Plica polonica*—may be brought about.

The eczema of young persons, which is localized in the nasal fossæ, and often transgresses the mucous surface, is of particular importance, as it may mark the starting-point of lupus of the nose.

In men with moustaches a scabbed form of eczema of the upper lip often results from nasal catarrh, and may lead to chronic folliculitis. The peri-oral region, as well as the vermilion of the lip, are not infrequently the seat of an obstinate form of eczema which is particularly troublesome, chronic, scaly, and complicated by fissures; it is often due to the use of unsuitable mouth-washes containing ethereal oils, thymol, etc. (*E. orbicularis oris*, Fig. 118).

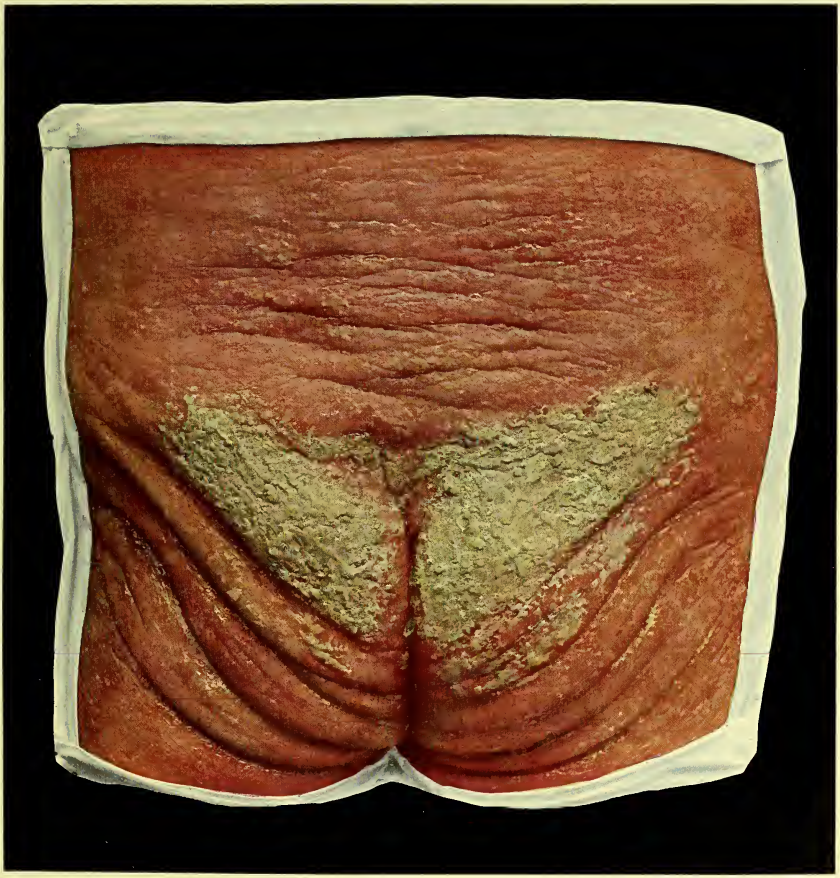
Eczema of the face with frequent relapses, or exacerbations, may result in a general thickening of the skin which resembles leprosy (*facies leontina*). Eczema of the ears is also extremely obstinate; it is often caused and kept up by chronic inflammatory or suppurative changes in the internal ear.

Trade-eczemas are generally localized on the hands, much less frequently on the feet, and they may occur on the backs of the hands (Fig. 119), as well as on the

palms. In such cases the irritants already mentioned come into play and may cause chronic, sharply demarcated patches or acute, vesicular and bullous eczema. When the backs of the hands are involved, the nails are often implicated and, as the result of exudation invading the nail bed, they may exhibit disturbances in their growth, or splitting and opacities of their substance (Fig. 115). Paronychia may also result.

The clinical picture of eczema is specially modified on the hands and soles owing to the thickness of their epidermis. The vesicles, which are so deeply situated as often not to be recognisable, cause a high degree of tension of the skin, as the result of which slight movements produce painful fissures. In certain trades (washerwomen, domestic servants, etc.), excessive production of epithelium with deficient cornification result in the accumulation of thick, horny masses, the eczematous origin of which can only be recognised round the margins, or after the removal of the horny callosities (Fig. 116). In more acute and more severe eczematous processes the epidermis is elevated in the form of large blebs, and the entire horny layer of the palm or sole is cast off, either in sheets or in large flakes. Complete cure is extremely difficult to accomplish in eczema of the hands, because it is seldom possible to hit exactly upon the precise etiological factor, and the patient's avocation generally compels him to resume it before recovery has taken place.

The lower legs are an extremely common seat of eczema; passive circulatory disturbances are of very frequent occurrence there as the result of varicose veins, and favour the development of chronic, scaly and partially weeping eczemas; these, in their turn, may give rise to deeper infiltration or even to elephantiasic thickening, especially when ulcers are added to the other changes present.



No. 117. Eczema madidans (rubrum).

The genital region is also a very frequent seat of eczema, which may be confined to the surfaces of skin in apposition, and due to the decomposition of the abundant sweat in this locality (especially in fat people), or it may be the result of mechanical irritation, and in other localities—*e.g.*, the mons veneris. The cause of eczema of this part is often the presence of pediculi pubis or of some ointment applied for their destruction. Diabetes is not infrequently the origin of genital eczema, which is the direct result of the decomposition of urine containing sugar. A frequently very obstinate form of eczema, either weeping, scabby or scaly, and attended by severe itching, often spreads to the anal region; but peri-anal eczema may also be the result of scratching in pruritus of the anus. Weeping or erythematous intertriginous eczema in other regions where folds of skin come in contact (mammæ, umbilicus, groins) is very resistant. Such intertriginous eczemas in children may, as the result of secondary infections, eventuate in deep ecthymatous ulcers which are extremely hard to cure, owing to the difficulty of excluding urine and fæces from them.

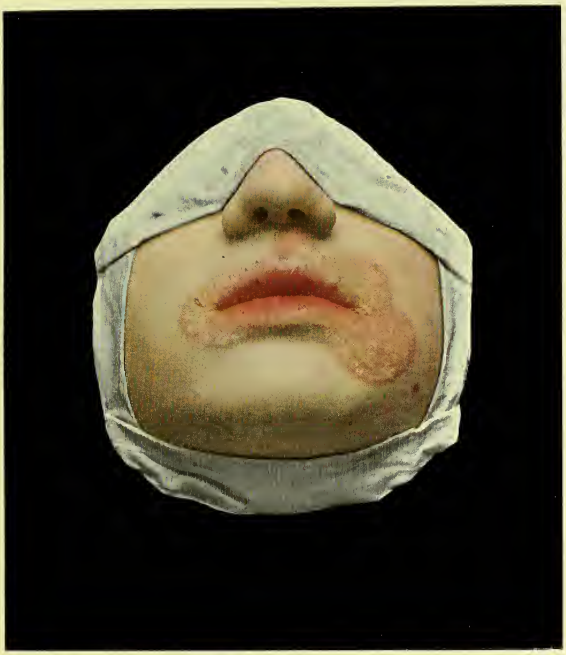
The so-called 'mycotic' eczemas demand special description. They result either from the migration of mycotic morbific agents (fungi), to eczematous surfaces, or mycotic patches, sharply demarcated and with special characteristics, develop from eczematous irritation. Their immediate cause is not yet definitely ascertained. First among them we consider *Eczema folliculare*, in which yellowish-red papules, localized round the follicles, occur in groups but may run together to form large, confluent, eczematous surfaces (Fig. 114).

*Eczema seborrhoicum sterni* (Lichen circumscriptus of Willan, flannel rash, eczema psoriasiforme) is very probably a disease of mycotic origin; in it a yellowish-

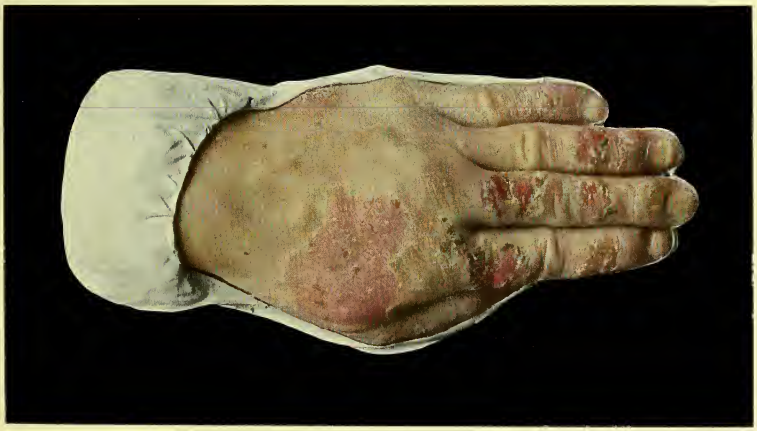
red patch with sharply-defined, curved outline appears over the sternum, the peripheral portion of which is covered with fatty, yellowish, firmly adherent scales. Follicular patches are generally present in the vicinity, as well as on the back, in the interscapular region (Fig. 122). The attempts recently made to identify this condition with psoriasis are utterly unjustified by facts.

The *Eczema seborrhoicum* of Unna may also own a mycotic origin; it may be associated with an existing seborrhœa of the scalp or may occur independently of that condition. Round, dry, scaly patches, attended by slight subjective symptoms, spread from the scalp over the neck and more distant parts of the body; they often show a tendency to extend in a serpiginous manner at the periphery and to heal in the centre; they are of yellowish tint and sometimes covered with fatty scales. The patches may become eczematous and discharge, owing to local irritation, sweating and scratching. The seats of predilection are the scalp and adjoining parts (Fig. 121), the neck, sternal region, armpits, navel, and parts surrounding the genitals; but isolated tracts may occur on the trunk. Some cases of this disease, which is, according to Unna, of extremely frequent occurrence and very protean in its manifestations, present close points of resemblance to psoriasis.

The **Diagnosis** of eczema can in most cases be easily established on the grounds of its multiformity, the presence of discharge, and its recovery without leaving scars. Itching is of importance and is never absent in typical cases. Acute eczema of the face is sometimes difficult to differentiate from erysipelas, but the high fever, the sharply-defined margin with tongue-shaped processes, as well as the pain of ery-



No. 118. Eczema orbiculare oris.



No. 119. Eczema e professione.

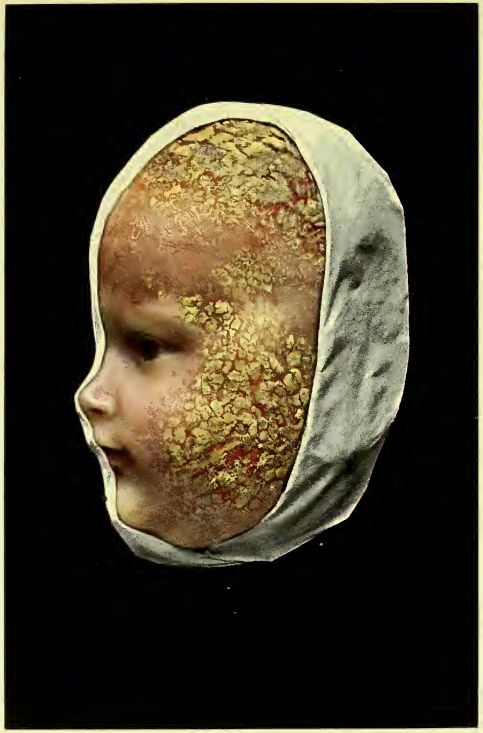
sipelas facilitate the diagnosis. Psoriasis never weeps, and its typical primary lesions, as well as scratch-marks, can be observed; but psoriasis may be complicated with eczema. Pityriasis rosea in its earlier stages sometimes resembles eczema but is easily distinguished as it progresses. Lichen planus is often mistaken for eczema, especially on the legs; but its characteristic tint, particularly at the margin, the subsequent development of discrete, typical primary lesions, as well as the invariable absence of weeping in lichen, generally settle the diagnosis. It is specially to be noted that in many diseases—such as scabies, pediculosis and prurigo—secondary eczematous changes form a part of the morbid picture, and the diagnosis is only arrived at after careful investigation (burrows, prurigo-nodules, *etc.*). Syphilides hardly ever itch, but the greater amount of infiltration and the characteristic 'bacony' or Burgundy colour generally show what disease one is dealing with, when the diagnosis is difficult between papulo-squamous syphilides of the palms or soles and squamous eczema of these parts; sometimes, however, the therapeutic test of anti-specific treatment is necessary. In the pre-mycotic stage of mycosis fungoides the greater depth of the infiltration may generally be recognised. In impetigo contagiosa the lesions, which arise from normal or only slightly reddened skin, are more abruptly marginated, and healing takes place more easily, than in impetiginous eczema.

The **Prognosis** of eczema is favourable in acute, but must be guarded in chronic, cases.

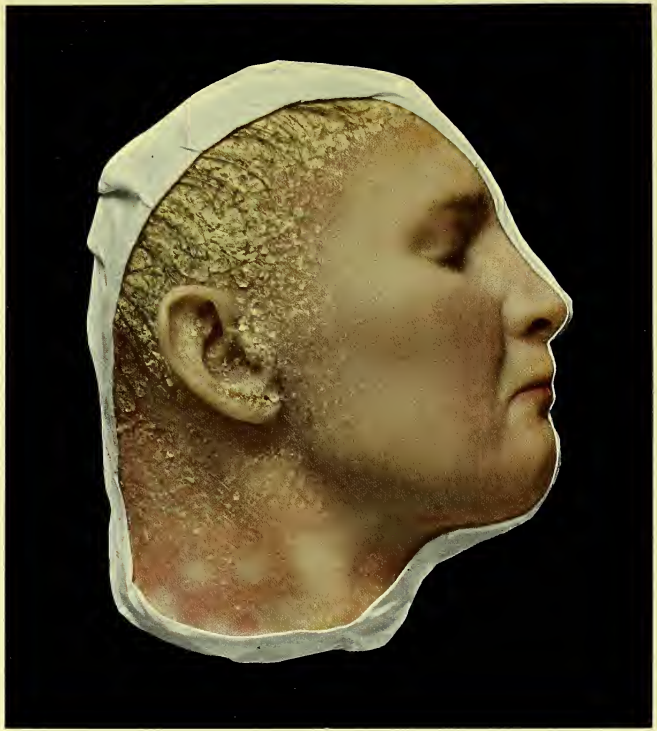
**Treatment.**—First of all, disorders of the general health or nutrition (anæmia, chlorosis, diabetes, *etc.*) must be dealt with. Food, and especially

the action of the bowels, must be regulated, but internal remedies have otherwise only slight influence on eczema. Even treatment with arsenic, which is so often tried, yields no definite results, and the same remark applies to ichthyol and similar substances. On the other hand, certain drugs—such as antipyrin, pyramidon and phenacetin—relieve itching, and the rest procured to the patient by hypnotics indirectly favours the cure of the disease.

The external treatment of eczema has for its primary object the removal of all ascertainable forms of irritation; then the skin must be put to physiological rest, protected from scratching by suitable dressings, and an outlet provided for any discharge which may be present. In the early inflammatory stages all possibly-irritating remedies must be proscribed; but they are thoroughly appropriate when it is desirable to provide a controllable amount of inflammation, in order to cause the absorption of a chronic infiltration. The itching of erythematous and papular eczema may be combated by alcoholic lotions containing salicylic acid (1 to 2 per cent.), menthol (2 to 4 per cent.), or thymol ($\frac{1}{4}$ to $\frac{1}{2}$ per cent.), while glycerine (up to 10 per cent.) or castor oil (up to 4 per cent.) may be added to counteract the tendency towards harshness of the skin. After the use of such lotions the parts may be dusted with starch, talc, fuller's earth, terra silicea, or similar substances. In this stage baths and soap are to be employed with the greatest caution, as they often cause severe irritation. The same remedies may be used in the vesicular stage, as long as the vesicles remain intact; but, if the inflammatory changes are more severe and pustulation occurs, the parts may advantageously be dressed with compresses soaked in such solutions as acetate of aluminium (1 per cent.), liquor plumbi subacetatis, boric acid (2 to 3 per cent.),



No. 120. Eczema chronicum infantum (Crusta lactea)



No. 121. Eczema seborrhoicum (Unna).

resorcin, or picric acid ($\frac{1}{2}$ to 1 per cent.). Both local and general baths ought to have medicinal substances added to them, such as borax, boric acid, permanganate of potash, *etc.* After the bath or washing, the parts ought to be painted with alcoholic lotions and subsequently powdered.

If weeping occurs, it is of prime importance that the discharge should not be allowed to stagnate and decompose upon the skin. This object may be attained, more or less satisfactorily, by the moist dressings already alluded to, and to these may be added solution of nitrate of silver ($\frac{1}{4}$ to $\frac{1}{2}$ per cent.) which may sometimes be employed after a preliminary touching with a similar solution of greater strength (up to 5 per cent.). Siccative pigments sometimes exert a very favourable action; these dry on the skin leaving a very absorptive deposit. As examples the following may be given :—oxide of zinc, talc, glycerine and water in equal quantities, with or without the addition of tannic acid (3 per cent.) or tumenol (5 to 10 per cent.); or a mixture of 20 parts of oxide of zinc, starch and glycerine, 40 parts of water being added; and resorcin, tannic acid or similar drugs may be incorporated with the mixture. It is also in this stage that pastes are useful, the oldest of which is known as Lassar's paste. Its formula is: oxide of zinc and starch, of each 25 parts vaseline 50 parts, or equal parts of oxide of zinc, starch, lanoline and vaseline. Smeared over the part, or applied on linen and fixed by bandages, it exerts a powerful absorptive influence and has practically no irritant action. It may here be remarked that all cutaneous remedies must be applied with the greatest care, as their efficacy depends not only on their nature but also on the method of their application.

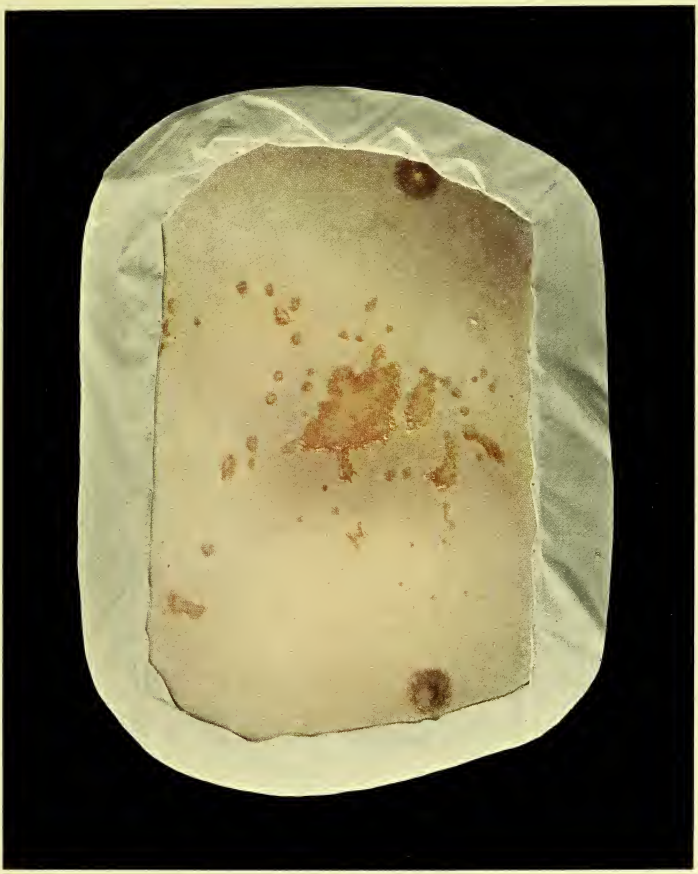
Casein-ointment, with or without additions; Unna's

gelanthum; and other remedies are similar in their action.

If thick crusts form they must be removed with oil, or with diachylon or bismuth ointment, before the treatment proper is begun. It is remarkable how different patients react differently to certain drugs; thus in some persons fats cannot be tolerated, while in others moist dressings, pastes, and similar remedies, provoke irritation. In every case it is not only the employment of certain forms of treatment, but their effect which has to be watched and controlled.

In the final stages of eczema, and in dry, chronic eczemas, the residua of inflammation must be removed by stimulating remedies. The principal of these is tar, which may be mixed in increasing proportions with salves or pastes already in use; it may also be gently insinuated into the treatment in the form of tar-baths or painting with tincture of tar, until finally the employment of tar-oil or pure tar is attained. Liquor carbonis detergens is less irritating in its action than common tar, and like tar acts advantageously by virtue of its anti-pruriginous properties. Tars may also be pleasantly and cleanly applied in the form of plasters—*e.g.*, salicylic-soap plaster. The powerful effects of tar may be obtained by the use of tar, green soap and sulphur (Wilkinson's ointment), but this preparation can only be utilized in the very last stage of eczema. Whenever tar is used it is wise to treat a small area at first, so as to watch its action.

The use of chrysarobin, till slight dermatitis results, is very valuable in the treatment of deep infiltrations. Pyrogallol and lenigallol (in the form of lenigallol and zinc paste) are often of service in chronic eczema. In extremely obstinate cases the use of baths, painting with solution of caustic potash, or the application of a layer of soft-soap, often produces an acute reaction



No. 122. Eczema seborrhoicum sterni (psoriasiforme).

which not infrequently ushers in recovery. As long as violent itching is present, or recrudescences manifest themselves, all powerful remedies must be left alone, until irritation ceases under treatment by pastes or ointments.

As the various forms of eczema show differences of character according to their differences of localization, the treatment used to prepare the parts attacked must also vary accordingly. On the scalp the removal of scabs is attained by using an oil-cap ; thick, piled up, horny masses on the palms and soles must be softened and separated by macerating plasters ; in peri-oral eczema the treatment may be begun by the application of a closely-fitting salicylic-soap plaster. Intertriginous eczemas demand not only systematic dressing but the most rigorous cleanliness, even after recovery.

After the removal of scales, seborrhœic eczema may be treated with sulphur, sulphur-resorcin, ichthyol, or chrysarobin-ointments, alternately with soapy, or resorcin and spirit lotions.

Figs. 113, 115, 119, 120, 121. Models in Neisser's Clinic in Breslau (Kröner).
Figs. 114, 122. Models in the Freiburg Clinic (Johnsen).
Figs. 116, 118. Models in Saint Louis Hospital in Paris (Baretta). Lailler's and Fournier's cases.
Fig 117. Model in Lassar's Clinic in Berlin (Kasten).

# Echthyma Gangrænosum.

Plate LXVIII., Fig. 123.

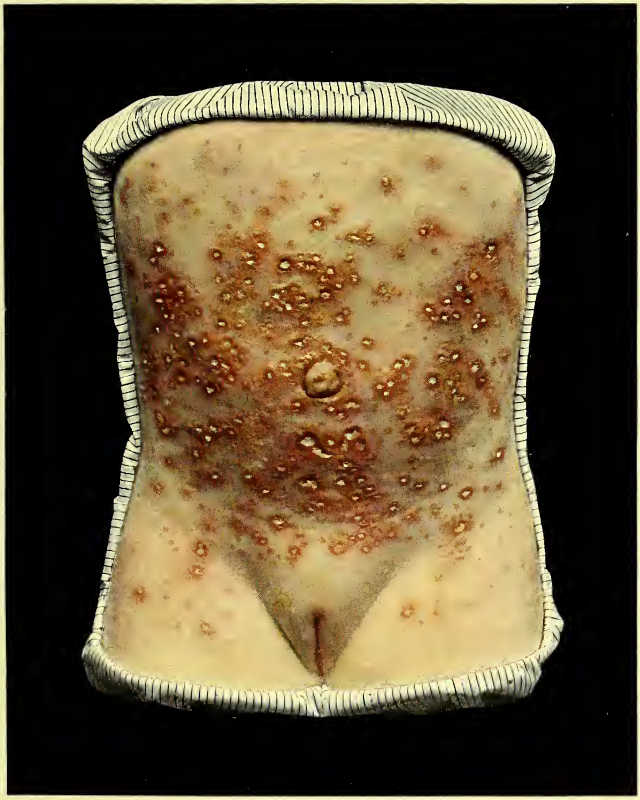
In very young, cachectic children ulcers may develop from scattered nodules, situate usually about the buttocks, but not infrequently also on the abdomen (Fig. 123). They are deep, punched-out, and have well-defined margins, while their base is covered by sloughy deposit; they may increase at the periphery and coalesce, so as to attain a considerable size. As a rule the children die, chiefly as the result of the essential cachexia, but sometimes from septicæmia. Infection from outside the economy is sometimes considered as responsible for the malady, and in some cases the presence of *bacillus pyocyaneus* has been demonstrated, due probably to contamination with urine and fæces.

The **Diagnosis** can easily be made from the sharply punched-out ulcers, in conjunction with the general cachexia.

The **Prognosis** is generally unfavourable.

The **Treatment** consists, first, in the removal of any active causal factor. Antiseptic dressings, sublimate-baths, and powdering with dermatol or iodoform, may sometimes exert a favourable influence on the disease, but it is generally transitory.

Fig. 123. Model in Kaposi's Clinic in Vienna (Dr. Henning).



No. 123. Ecthyma gangraenosum.

# Impetigo Contagiosa.

Plate LXIX., Fig. 124.

The affection called Impetigo contagiosa is usually met with in children, but sometimes attacks adults also. Groups of superficially situated blebs of different sizes, appear on exposed parts of the body ; their contents soon become cloudy, and rapidly dry up to form bright yellow, translucent scabs, at the margins of which the remains of the small blebs can often be recognised (Fig. 124). The inflammatory phenomena are trifling, as well as the general symptoms, which frequently are not present at all. After removal of the crusts the lower layer of the rete Malpighii is exposed ; there is no deep loss of substance but occasionally slight papillary hypertrophy may be observed. Relapses often occur owing to the spread of the extremely infective contents of the vesicles, so that the duration of the disease may be prolonged for several weeks. The individual lesions soon heal up without scarring, but leave behind reddish spots which afterwards become pigmented. It is a remarkable fact that there are no subjective symptoms, such as itching, but there is generally swelling of the neighbouring lymphatic glands. The disease usually occurs in epidemics, which may assume considerable proportions.

**Etiology.**—Bacteria are held to be the cause of the disease, and these are most probably *streptococci.*

In a large number of cases described as Impetigo contagiosa, pediculi capitis are present, so that the affection is entirely attributed to them by some authors. As the disease can be communicated by inoculation with the pure contents of the pustules, the presence of parasites need not be proven in cases of impetigo, undoubtedly caused by pediculi.

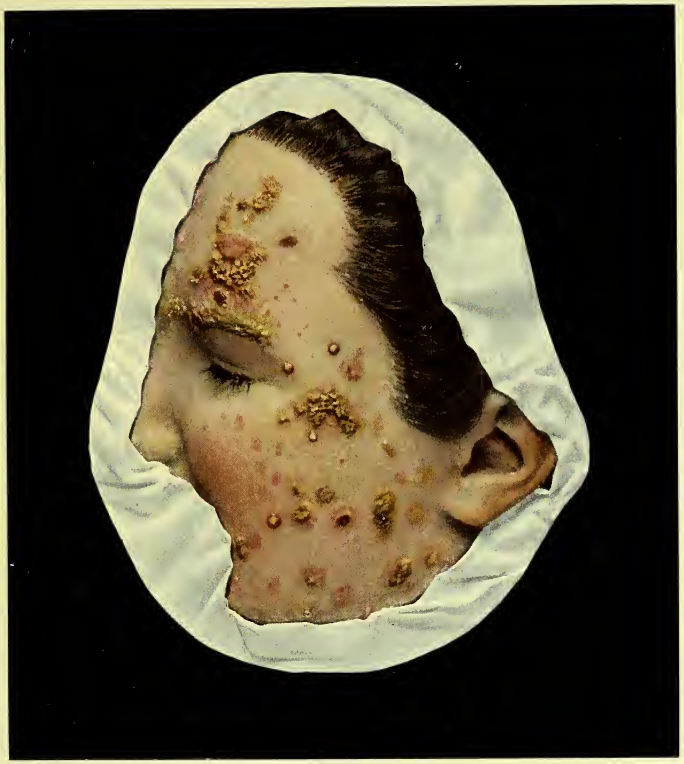
The **Diagnosis** can usually be easily made on the grounds of the acute onset, the sharply-defined lesions, the yellow crusts and the absence of itching.

The **Prognosis** is favourable.

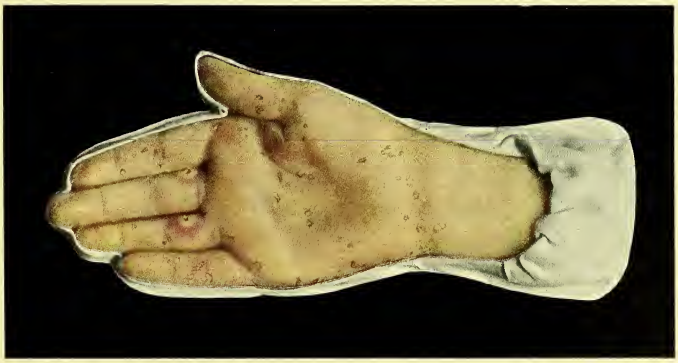
The **Treatment** consists, first, in the softening of scabs with oil or salves, after which sulphur-ointments may be used. To these cinnabar (1 to 5 per cent.) may be added, and cure is usually obtained in a short time. The surrounding parts may advantageously be cleaned with thymol-spirit ($\frac{1}{4}$ to $\frac{1}{2}$ per cent.), or with an alcoholic solution of corrosive sublimate ($\frac{1}{2}$ to 1 per cent.), in order to prevent the spread of the disease.

Fig. 124. Model in the Freiburg Clinic (Johnsen).

NOTE.—The familiar Ung. Hydrargyri Ammoniati has almost a specific action in Impetigo, but it is little known in Germany.—J. J. P.



No. 124. Impetigo contagiosa.



No. 125. Scabies.

# Scabies.

Plates LXIX., and LXX., Figs. 125-127.

If an impregnated female itch-insect (*acarus scabiei*, *sarcoptes hominis*) gains access to the skin, it penetrates in order to obtain nourishment and to deposit its eggs, thus forming a 'burrow' between the horny layer and the rete Malpighii which, at its proximal end, is slightly raised; while the insect can be recognised at its distal end as a whitish point about a fifth to a third of a millimetre in diameter. These burrows are most easily recognised on the opposing surfaces of the fingers and on the wrists, on the palms and soles in children (Fig. 125), and on the penis; they appear as zigzag, whitish lines in which dark points often may be seen, due to dirt, especially the excreta of the insect. The skin at the affected spot is often infiltrated and raised in the form of a tiny papule, at the apex of which is a small blood-crust. In other cases a pustule forms, in the roof of which the burrow courses. The males live only in the superficial, shallow depressions of the epidermis. All other symptoms of scabies are secondary and, for the most part, due to the terrible irritation caused by the burrowing of the insect. There are present, on the one hand, changes directly referable to scratching, in the form of excoriations, scratch-marks and eczematous conditions; and, on the other, infective processes due to the penetration of pyogenetic cocci into the epithelial lesions; of such nature are the pustules so common in children, and the acneiform nodules (Fig. 126), while sometimes even carbuncles may result. If the condition prove of long

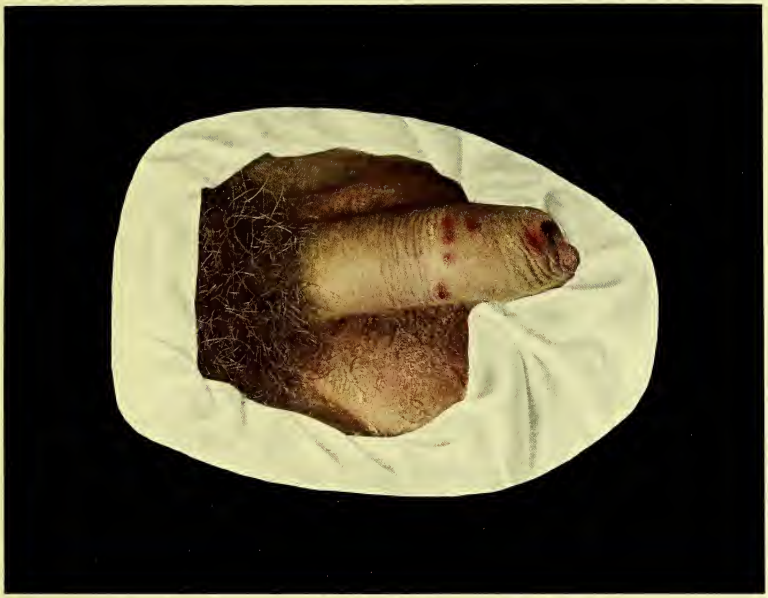
duration, deep pigmentation may be caused by the violent scratching, exactly as in pediculosis. In certain circumstances not yet fully understood, an extraordinarily severe form of scabies occurs, where the skin is densely infiltrated and covered with thick scabs, in which the parasites are present in very unusual abundance (*scabies Norvegica*).

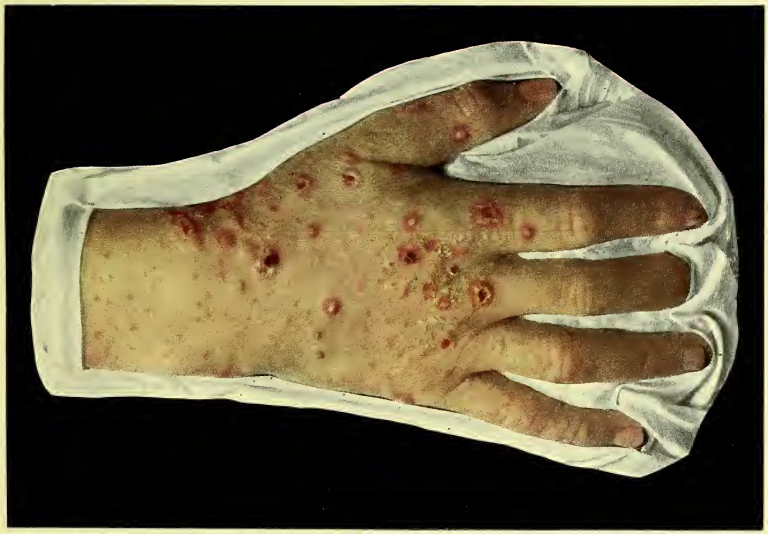
The changes described occur on any part of the body excepting the face ; their seats of predilection are the axillary folds, the nipples, the waist, the umbilical region and the penis. In the latter situation very typical, elongated lesions, often covered with a scab from scratching, are frequently present (Fig. 127). All parts touched by the clothes are prone to be affected, as well as regions exposed to regular pressure by the patient's trade—*e.g.*, the buttocks in tailors and shoemakers.

Although scabies has no direct influence on the health, the general condition may suffer from the intense itching, which is especially severe when the patient is warm in bed. Complications, such as erysipelas and cellulitis, are rare.

Scabies is almost always directly communicated from one person to another by the migration of an impregnated female or of a pair of acari, and this generally results from occupying the same bed. It is, therefore, commonest in artisans, apprentices and mates, as well as in prostitutes.

The **Diagnosis** is most surely made by the demonstration of the parasite ; this may be done by removing a burrow or by digging out an acarus, and subsequent microscopical examination. But the localization of the scratch-marks in the above-mentioned sites and the presence of long, infiltrative lesions on the penis, will in many cases suffice to fix a diagnosis





No. 126. 127. Scabies.

without the demonstration of the acarus or its burrows. Other itching affections come into the differential diagnosis, such as pediculosis, prurigo, and urticaria, but all have a different distribution and primary lesions.

The **Prognosis** is favourable, as scabies can be cured with certainty in a short time.

The **Treatment** consists in using remedies which destroy the parasite, the chief of which are balsams (balsam of Peru, styrax), either pure or diluted with spirit. Nicotine-soap and Wilkinson's ointment may also be used for several consecutive days. Kaposi's 10 per cent. β-naphthol-ointment with the addition of soft-soap is also much employed, as a few inunctions are sufficient to cure the scabies; the treatment must, however, be applied with some caution, as it sometimes produces toxic effects and renal irritation. A non-poisonous naphthol-preparation—epicarin—has a similar action and may be used without danger. The rapid treatment of scabies by painting with Vlemingkx' solution often irritates greatly and must not be used to a delicate skin. Sulphur-ointment, the strength of which may be raised to 30 per cent., is much employed; the patient must be rubbed all over with it, and only have a bath with soap some days afterwards.

A sensation of severe itching often persists after scabies has been cured; it may be controlled by alcoholic spirit of tar or tar-ointments. An eczematous condition which sometimes remains behind may be similarly treated.

Fig. 125. Model in Neisser's Clinic in Breslau (Kröner). Extraordinarily numerous burrows in a boy, six years old.
Figs. 126, 127. Models in the Freiburg Clinic (Johnsen).

# Melanodermia e Pediculis vestimentorum.

## Pigmentation from Body-lice.

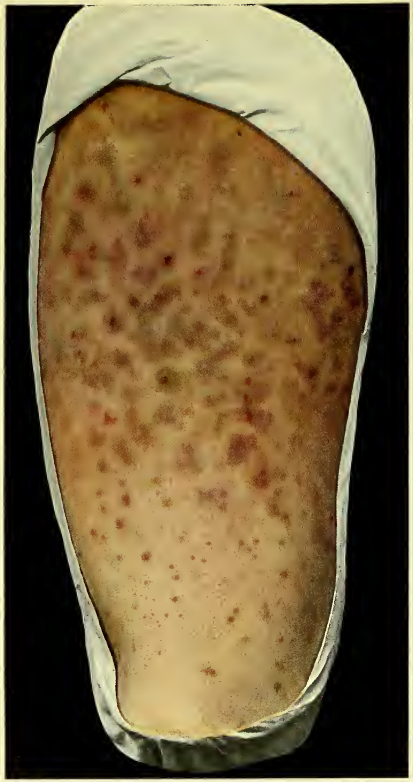
Plate LXXI., Fig. 128.

The extremely severe itching caused by the presence of body-lice compels any person affected with them to scratch violently and thus produce characteristic, longitudinal wheals, which become excoriated where the nails have penetrated most deeply. These excoriations leave pigmented scars after healing. If anyone suffers frequently from pediculosis the pigmentary spots may coalesce into large patches, and the staining may be so intense as to suggest Addison's disease; melanodermia is, however, easily differentiated by its superficial scars, which often stand out as whitish spots amidst the surrounding pigmentation (Fig. 128).

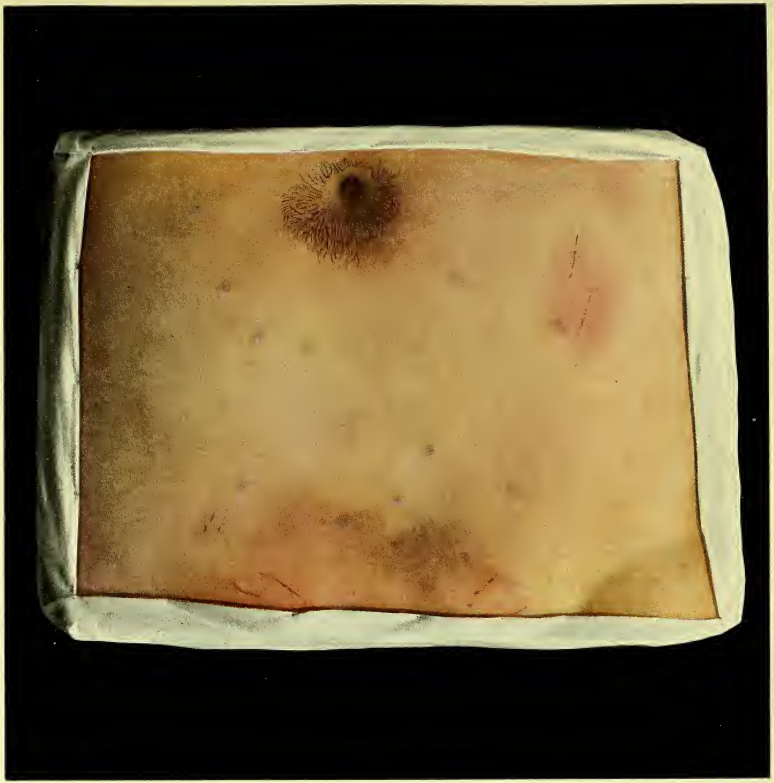
The **Diagnosis** can be made without difficulty from the effects of scratching described, and from their localization about the neck, waist and buttocks. The presence of the parasites in the clothing can also be often detected.

The **Treatment** consists in removing the lice, which is simply accomplished by changing the underwear. The pigmentation disappears extremely slowly and, in marked cases, only incompletely.

Fig. 128. Model in Neisser's Clinic in Breslau (Kröner).



No. 128. Melanodermia e pediculis vestimentorum.



No. 129. Maculae caeruleae; Phthiriasis pubis.

# Maculæ Cæruleæ.

Plate LXXI., Fig. 129.

Pediculi pubis (*morpiones*, *crab-lice*) are generally found on the mons veneris in adults; thence they may migrate to the upper parts of the thighs, to the armpits, sometimes to the beard, eyebrows, eyelashes and —very rarely—to the scalp, in children. They provoke itching, which is never so severe as that caused by body-lice, but in some cases, especially when warm in bed, the patient may be considerably annoyed thereby. Particular interest attaches to the occurrence of dull-blue or violet spots on the abdomen (Fig. 129), sides of the chest, and upper parts of the thighs, which are due to a colouring matter special to these pediculi. The spots give rise to no subjective symptoms, but they are of importance as they sometimes have been mistaken for common and for syphilitic roseola, and even for the rash of typhus-fever.

The **Diagnosis** of maculæ cæruleæ can be made without difficulty on the grounds of their special colour, the absence of infiltration, the presence of crab-lice, and the scratch-marks, which are usually present.

**Treatment** consists in exterminating the parasites by the use of sublimate-glycerine ($\frac{1}{4}$ to $\frac{1}{2}$ per cent.) or naphthol-ointment (2 to 3 per cent.). Mercurial oint-

ment, which is often employed, had better be avoided; it frequently causes in the region of the mons veneris a severe dermatitis, which sometimes spreads over the whole body. The maculæ soon disappear spontaneously.

Fig. 129. Model in Lassar's Clinic in Berlin (Kasten).

# Alopecia Areata.

Plate LXXII., Fig. 130.

A sudden loss of hair in patches, from perfectly healthy skin, is often observed on the scalp and on hairy parts of the face and trunk. The condition is known as *Alopecia areata* or *Area Celsi* (Fig. 130); it is associated with trifling, or no, subjective symptoms. The hairs in the neighbourhood are twisted while, here and there, single broken stumps are present. After the baldness has persisted for a more or less prolonged period, fine non-pigmented, downy hairs appear, which usher in recovery.

The form just described usually gets well after some months but the prognosis of *universal alopecia*, in which all the hair—including the lanugo—falls, is much more unfavourable; but recovery has been observed in one case of this nature after eighteen years' duration. It is doubtful whether the condition of alopecia beginning on the necks of children under twelve years of age, which has been described by Sabouraud as a separate disease (*ophiasis*), should be accepted as such.

The **Etiology** is not yet established; its occasional occurrence in epidemics and the undoubted communicability of the disease, favour the idea of its infective origin. The pathogenetic properties of the bacilli found chiefly in the contents squeezed out of the follicles—and considered by some as a specially

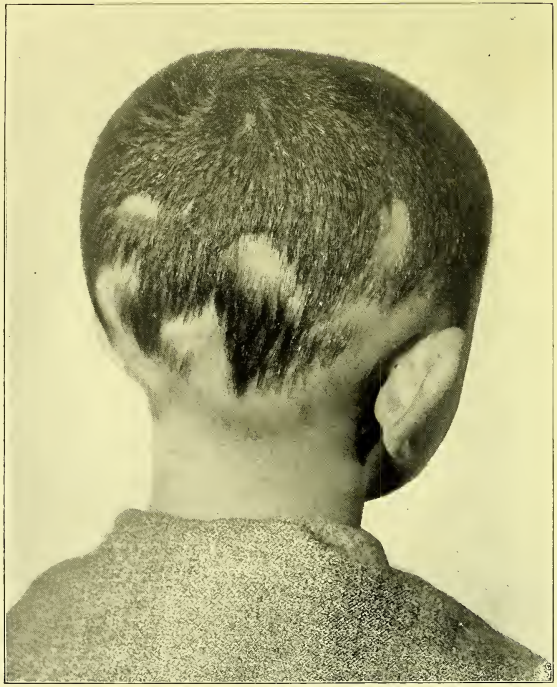
virulent variety of the seborrhœic bacillus — have not been proven.

The **Diagnosis** can easily be made from the sudden onset, the normal character of the skin affected, and the circular outline of the patches.

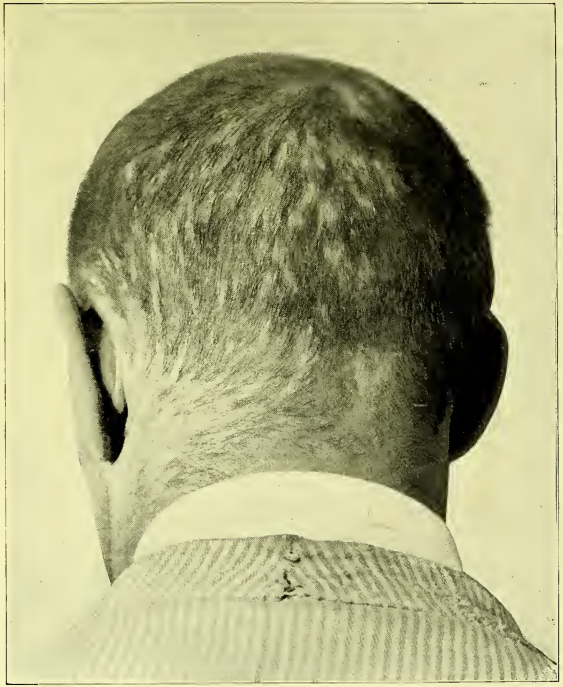
The **Prognosis** of circumscribed alopecia is almost invariably favourable, that of total alopecia dubious. In order to avoid all risks of spread of the disease, it is a good measure of precaution to isolate affected persons and to veto the common employment of brushes and combs.

There is no specific **Treatment** of Alopecia areata, and it is difficult to estimate the value of remedies owing to its tendency to spontaneous recovery. Bactericidal substances are chiefly used, especially those which exert an irritating effect on the skin. It is well to shave the scalp for some distance outside the spot before beginning treatment. Then, naphthol or chrysarobin ointments may be rubbed in, alcoholic solution of sublimate used as a lotion, or liquid carbolic acid lightly dabbed on. Sulphur and tar ointments, croton oil, tincture of tar or cantharides, cantharides-plaster, faradization, *etc.*, may all be tried. Lassar's 'hair-cure' is much practised; it consists of rubbing with tar, or tar and sulphur soap, clearing this away, then washing with a 1 per cent. watery solution of glycerine of sublimate, rubbing with naphthol-alcohol ($\frac{1}{2}$ to 1 per cent.) and finally oiling. Good results from Finsen's light-treatment have also been recorded.

Fig. 130. Photograph in the Freiburg Clinic.



130. Alopecia areata.



131. Alopecia syphilitica.

# Syphilis.

PLATES LXXII.-LXXXV., FIGS. 131-155).

SYPHILIS was first observed to prevail as an epidemic in the year 1493, during the siege of Naples. It is a chronic, infective disease, directly or indirectly communicable, and its duration may extend over years. In most cases one attack affords immunity for life.

The exciting cause of syphilis is not yet recognised; but it is possible that the 'syphilis-bacilli,' which have been often observed, are authentic, although the methods used for their demonstration are not sufficiently elaborated to be of practical utility. In the great majority of cases syphilis is communicated during sexual relations, but it may be otherwise (*syphilis insontium*). After a certain incubation-period, usually of from eight to twenty days, the primary sore or so-called initial sclerosis manifests itself at the point of entry of the virus. General infection may, however, take place without any primary lesion, if the poison is introduced directly into the circulation (*syphilis d'emblée*). The primary sore is generally single, but may occasionally be multiple, and appears first as a small erosion, papule, or vesicle, with very ill-defined characters. Some weeks after inoculation a flat, nodular lesion of varying size and cartilaginous consistence, which lies within the skin, develops, and represents the typical initial sclerosis (Fig. 132). A flat, parchment-like patch or a deeper, denser nodule

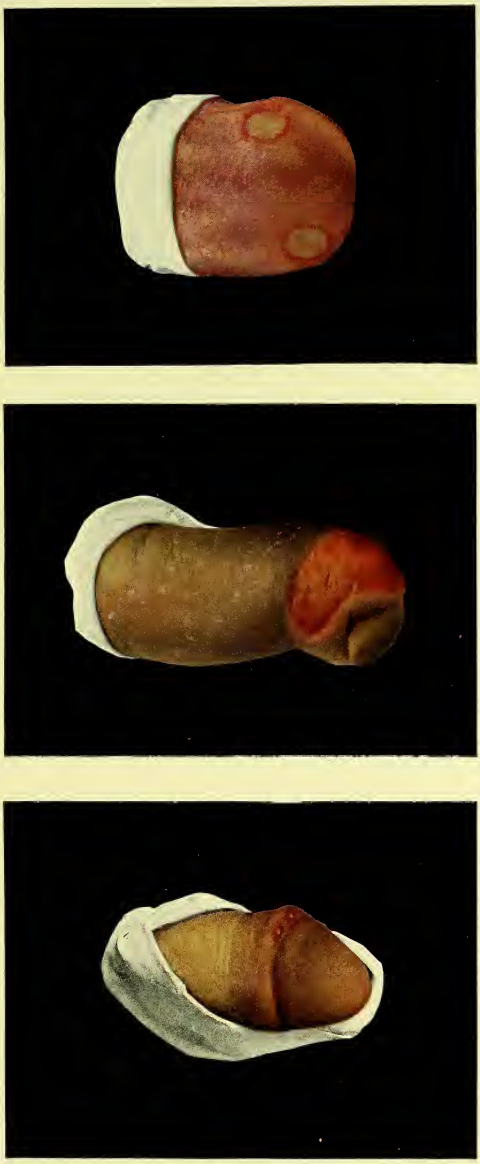
forms, according as the superficial or deep vascular reticulum of the skin is involved; the former variety is specially frequent on the glans penis.

The primary sore may be covered by intact skin or its surface may be eroded, or shiny as if varnished. Subsequently it may ulcerate or become gangrenous, and thus spread in depth and area. Superficial extension of the sore is very common on the prepuce (Fig. 133), and on the body of the penis. Induration is not infrequently absent in extra-genital chancres, the commonest seats of which are the lips (Fig. 135), the fingers (Fig. 136), and the tonsils; other parts — *e.g.*, the tongue (Fig. 134), may also be affected. Sometimes the primary sore is covered by a thick scab (Fig. 135). If the viruses of soft chancre and of syphilis are inoculated together, either one or more of the soft sores which appear first, will subsequently become indurated and converted into a hard chancre (*Chancre mixte*).

The corresponding lymphatic glands are next involved through the lymphatic channels. They enlarge, either singly or in chains, to form hard, painless lumps of considerable size, especially when the chancre is extra-genital; they may even suppurate, particularly in the case of mixed chancres. When general symptoms appear on the skin and mucous membranes, the lymphatic glands over the trunk swell, especially in the nape and on the sides of the neck, in the axillæ, and in the bends of the elbows.

The primary sore may persist without treatment for a long time, but it finally disappears and often leaves no scar, but only a transitory pigment-spot.

The **Diagnosis** of a primary syphilitic chancre may be made from its cartilaginous hardness and often from the varnished appearance of its surface. The



No. 132. 133. 134. Scleroses syphiliticae.

swelling of the corresponding lymphatic glands will confirm the diagnosis; but it must always be remembered that unsuitable treatment, often employed to simple erosions, soft chancres, etc.—such as burning with nitrate of silver—may give rise to an induration exactly like a hard chancre. The swelling of the corresponding lymphatic glands is also no sure criterion, as it may be mimicked by other processes. Proof of the source of infection facilitates diagnosis, but, on the other hand, history often greatly aggravates its difficulty owing to the carelessness and unreliability of such patients. A tertiary lesion (*cancrum redux*), which frequently appears on the site of the primary sore, often also gives opportunities for errors of diagnosis as regards the occurrence of syphilitic re-infection. The so-called secondary stage of syphilis begins from seven to twelve weeks after infection, or four to six weeks after the appearance of the primary sore; it is accompanied by malaise, headache, fever, anorexia, pains in the joints, and manifestations on the skin and mucous membranes.

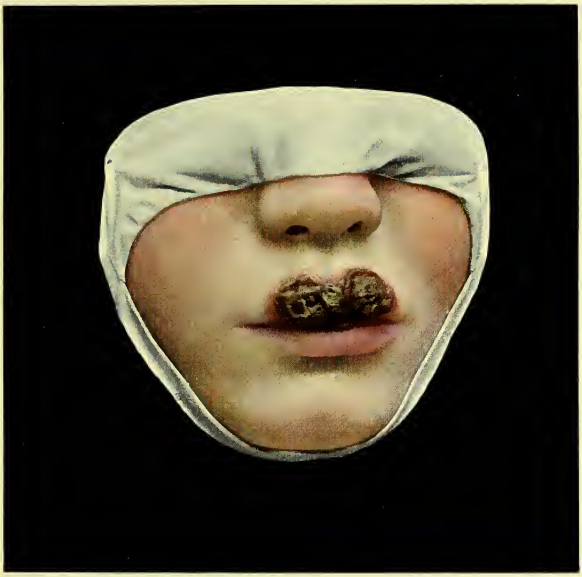
Cutaneous syphilides, which constitute the principal signs of this period, have a number of characteristics, the most important of which are the following: dense infiltration — absent in macular syphilides only— absorption without the formation of fibrous tissue, tendency to peripheral extension with healing in the centre, localization on the flexor surfaces of the limbs and on the palms and soles, as well as round the apertures of the body (mouth, nostrils, anus). Their brownish-red colour does not entirely disappear on pressure, they show a tendency to arrange themselves in groups, and they are attended by no itching.

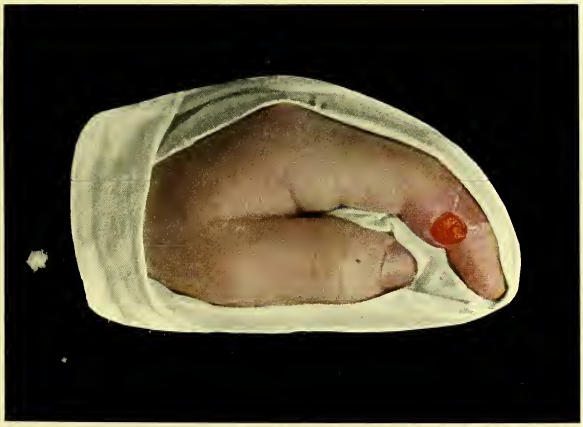
The first rash is generally a macular syphilide (*Roseola syphilitica*), and very often all prodromal symptoms cease on its appearance; it consists of

numerous, bright-red spots, occasionally intermingled with very flat papules, measuring from $\frac{1}{4}$ to 1 centimetre in diameter. They are localized chiefly on the trunk, chest (Fig. 137) and back, on the flexor aspect of the limbs and, more rarely, on the face. The administration of mercury causes some œdematous swelling of the spots present, and the eruption of fresh spots. In a few days, or frequently only after some weeks, the rash disappears without desquamation.

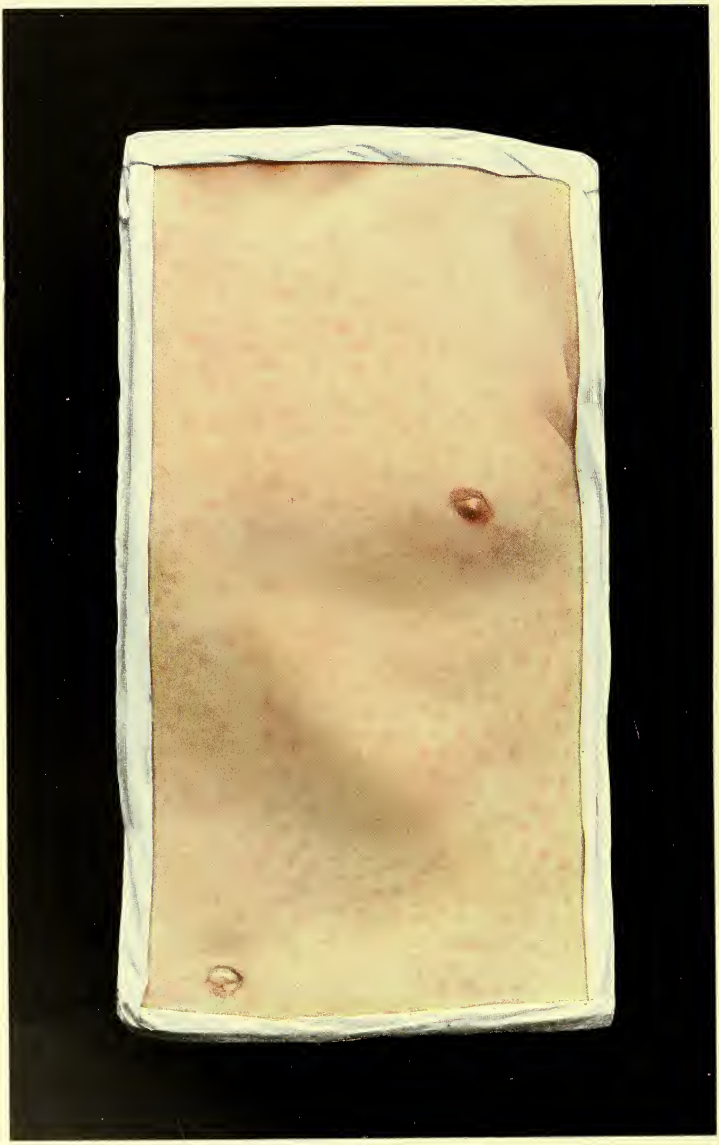
A second macular eruption (*Roseola recidiva vel annularis*, Fig. 138), may develop sooner or later after the disappearance of the first rash; it assumes the form of flat, red rings round some of the original spots and these may coalesce to form serpiginous figures.

If granulation-tissue is formed in greater abundance, the result is the formation of papules instead of macules; such *papular syphilides* may appear as the first rash of syphilis, but more frequently represent relapses. They manifest themselves as sharply-defined nodules, lentil-sized and shiny reddish-brown in colour (*lenticular syphilides*, Fig. 139); they may be universally distributed or confined to some of their seats of predilection—*e.g.*, the margin of the scalp in the frontal region (*corona veneris*), round the apertures of the body (mouth, nostrils, anus), the flexor aspect of the extremities, or the palms and soles, in which latter situation the epidermic covering may be exfoliated in rings (Fig. 142). Larger patches are often formed by the confluence of papules, and these patches may have unaffected areas of skin in their centre. Ringed eruptions may also result from central healing and peripheral spread of papules, or by the grouping of papules in circles (*annular and circinate syphilides*, Fig. 141); they exhibit the same localization as simple papular syphilides and, like them, often desquamate





No. 135. 136. Scleroses syphiliticae.



No. 137. Syphilis maculosa (Roscola).

freely and leave considerable deposits of pigment after their absorption.

Where surfaces of skin are in contact, and especially if the mechanical irritation of rubbing is added to the chemical irritation of decomposed secretions (sweat, leucorrhœal discharge, etc.), syphilitic papules may assume a condition of overgrowth resulting in the production of large, considerably raised plaques, the surface of which may discharge and become eroded or covered by diphtheritic-like sloughs (*flat condylomata*, Fig. 143). These condylomata, like the papules which occur on the palms, soles and at the angles of the mouth, are often complicated by fissures; they usually represent relapses and may recur very frequently in the course of an attack of syphilis. The extremely infectious discharge from flat condylomata is the commonest cause of the communication of the disease. The primary sore may sometimes assume the characters of a flat condyloma, from local irritation.

The *small papular syphilide* (Fig. 145) generally occurs as a relapse-manifestation, a long time after infection, and in cachectic individuals; it is seldom seen in the early stages of an attack. It consists of small, pointed, lichenoid papules, chiefly localized round the follicles, and arranged in groups or circles, sometimes associated with larger papules. After the disappearance of a large papular syphilide, these small papular syphilides are sometimes found to be present round the margin of the pigment spots left behind. This very obstinate eruption often gives rise to confusion with lichen scrofulosorum and lichen planus.

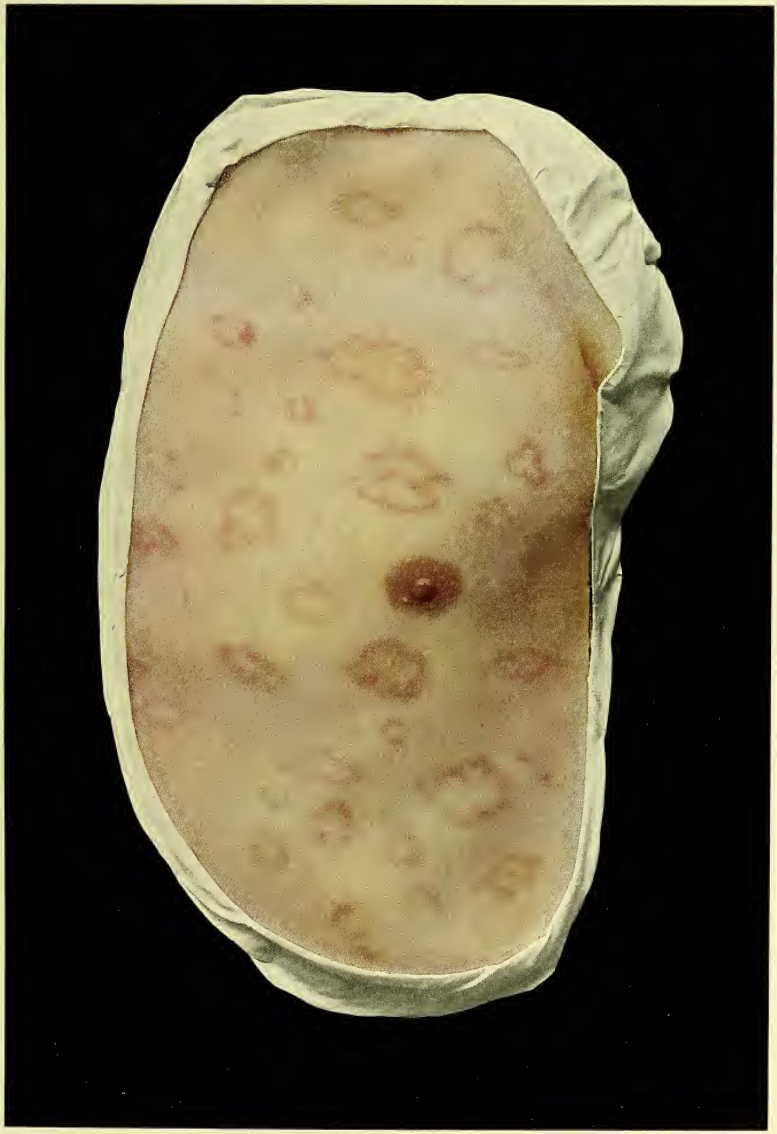
The *pustular syphilide*, often associated with papular lesions, also occurs chiefly in cachectic individuals; it is found principally on the forehead (Fig. 144) and legs, and every pustule arises from an infiltrated papule.

A general pustular eruption may appear in the earlier stages of syphilis, or may do so a long time after infection, when it develops in groups and often in circles. A difference is made between 'large pustular' and 'small pustular' syphilides, according to the size of the lesions. Most pustules soon dry up and form scabs, after the separation of which papules remain behind with loss of substance, of very variable size, in their centres. They may also result in the formation of deep ulcers.

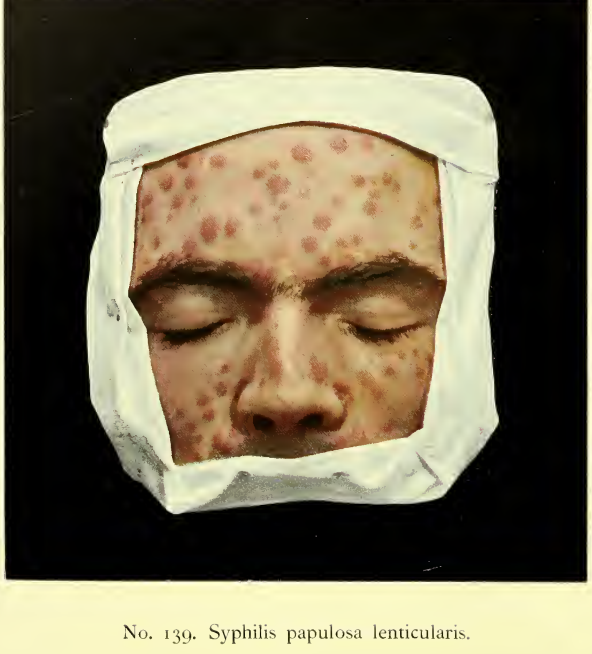
*Leucoderma syphiliticum* is a specially characteristic, residual lesion, which manifests itself after the subsidence of macular and papular syphilides. It occurs chiefly in women and most frequently on the neck, but may occur on any deeply pigmented part; it appears as round or oval, sharply-defined patches, devoid of pigment, between which the pigmented skin has a reticular arrangement (Fig. 146). It is totally uninfluenced by treatment, remains for years unchanged, and is an infallible sign of comparatively recent syphilis.

A peculiar form of *Alopecia*, characteristic of syphilis, not infrequently affects the scalp (Fig. 131), as well as the beard, eyebrows and eyelashes; the hair falls in roundish, but not quite bald spots, so that the scalp assumes a curious, spotty appearance. Recovery usually soon sets in.

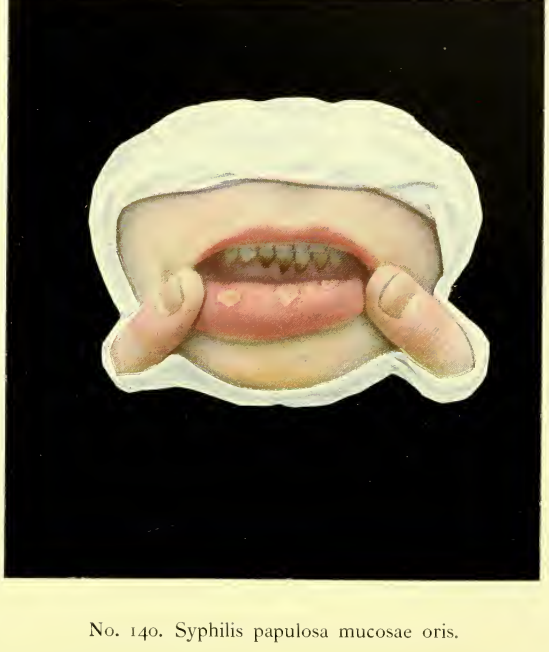
A macular syphilide, which at first has few special characters, appears on the buccal mucous membrane. It corresponds to the roseola on the skin and usually coincides with it in point of time. When papular rashes develop, these manifestations assume a typical appearance; their margins become deep-red, while their centres become obscured by thickening of their epithelium and assume a milky, opalescent, whitish colour (*plaques opalines*). Subsequently they may



No. 138. Syphilis maculosa recidiva (Roseola recidiva).



No. 139. Syphilis papulosa lenticularis.



No. 140. Syphilis papulosa mucosae oris.

heal in the centre and spread at the margin, or the mucous membrane may disintegrate, forming very shallow, sharply-demarcated ulcers covered by sloughs, which are either firmly adherent and diphtheritic looking, or pultaceous and easily detached. These lesions are chiefly found on the tonsils, the arches of the palate, the uvula, the lips (Fig. 140), and the margins of the tongue, as well as on the cheeks and hard palate, especially on parts exposed to mechanical irritation. Sometimes deep ulcers, which leave a white scar after healing, may result from these plaques. Lesions of this nature seldom attack the conjunctiva or nasal mucous membrane, but they are, on the contrary, very common on the female genitals and in the rectum. The so-called 'secondary' syphilides, just described, occur in one form or another in every case of syphilis in direct association with the primary sore, or as relapse eruptions, in the course of the first two years.

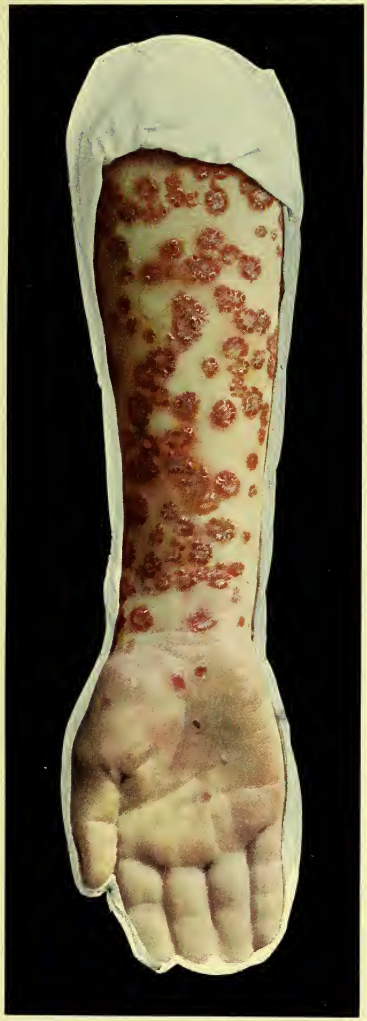
So-called 'tertiary' phenomena may, in exceptional cases (*syphilis precox*), manifest themselves within the first two years, but beyond that period they represent the sole symptoms of syphilis and may appear at any length of time after infection, especially in cases which have been untreated, or imperfectly treated, or have not been diagnosed.

The principal forms of tertiary manifestations are the *tuberous* or *nodular syphilides*, which occur in groups and spread at the margin, and the isolated *gummatous ulcer*. The latter appears as a hard lump, lying in the skin or subcutaneous tissue, which slowly increases in size, becomes red or livid in colour and then softens; the mass is eventually absorbed with some cicatricial retraction of the skin, or it bursts and discharges its sticky contents. The ulcers thus formed are punched out, and their base is covered with necrotic débris, or with a gray or grayish-yellow slough

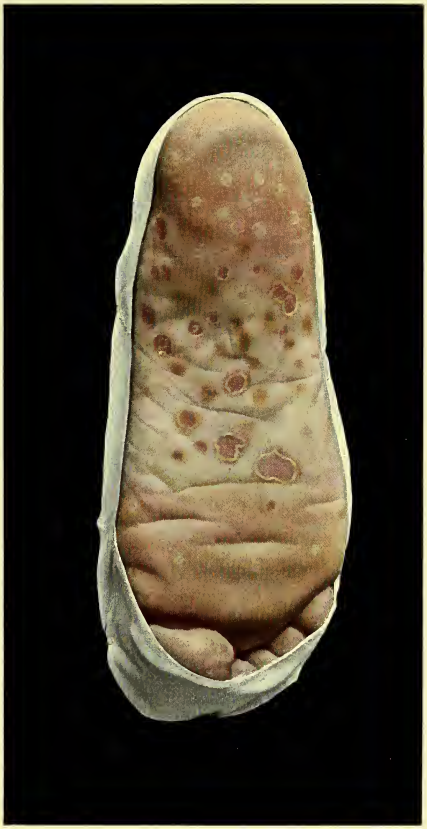
(Fig. 151). As the new-growth spreads and breaks down, extensive and deep ulcers form, which have their origin not only in gummata of the skin alone but also in similar lesions in the deeper tissues,—bones, muscles and glands. The healing of gummata is always followed by the formation of scars, or cicatricial contraction of the skin; it seldom takes place spontaneously, and only after a prolonged period.

Tuberous or nodular syphilides, in contrast to isolated gummata, always appear in considerable numbers and in groups; these are made up of single, firm papules—as large as a lentil or pea,—of a bright-red colour which subsequently becomes brown or reddish-brown. After a certain time they disappear and new nodules often appear in the neighbourhood; they may run together and form characteristic serpiginous lesions by extending at their margins and healing in the centre — the *tubero-serpiginous syphilide* (Fig. 149). If such nodules break down, ulcerate, and then heal in the centre with actively ulcerating margins, kidney-shaped lesions often result, which are very typical of syphilis — the *tubero - ulcero - serpiginous syphilide* (Fig. 153). Its seats of predilection are the face, especially the nasal and frontal regions, and the legs, where elephantiasis is a common complication. Tertiary syphilides of this sort also occur on the palm (Fig. 150), and may be difficult to differentiate from secondary papulo-squamous syphilides.

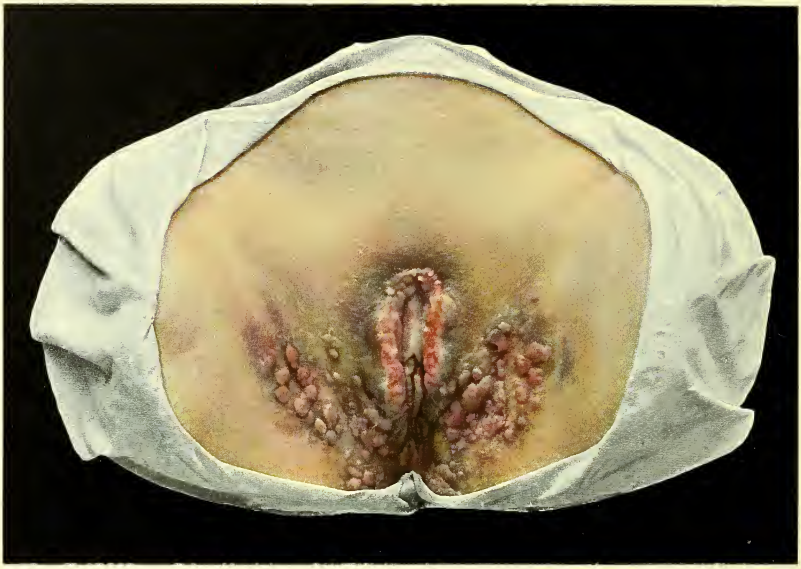
Late syphilides of the buccal mucous membrane have a great tendency to rapid disintegration and, therefore, are seldom observed in the form of nodules; gummatous ulcers may be present on the lips, cheeks, gums and tongue, either singly, or as extensive ulcerated gummata (Fig. 152), as superficial or deep nodules with a marked tendency to break down, or, finally, as diffuse gummatous infiltrations. Such lesions in the



No. 141. Syphilis papulosa orbicularis.



No. 142. Syphilis papulo-squamosa.



No. 143. Syphilis papulosa (Condylomata lata).

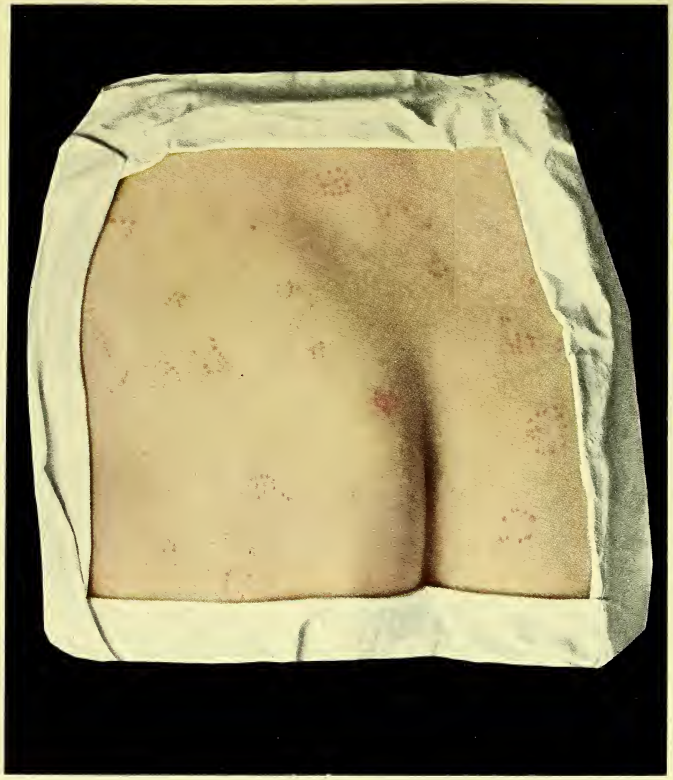
No. 144. Syphilis pustulosa.

hard palate usually lead to its perforation from destruction of bone. Ulcerative processes attack the soft palate with great rapidity, and cause extensive destruction of the tonsils and uvula with perforation, so that after healing has taken place the relationships of the parts may be almost irrecognisable, owing to cicatricial contractions. Severe cicatricial stenosis of the pharynx and upper part of the œsophagus may also result from gummatous ulceration there.

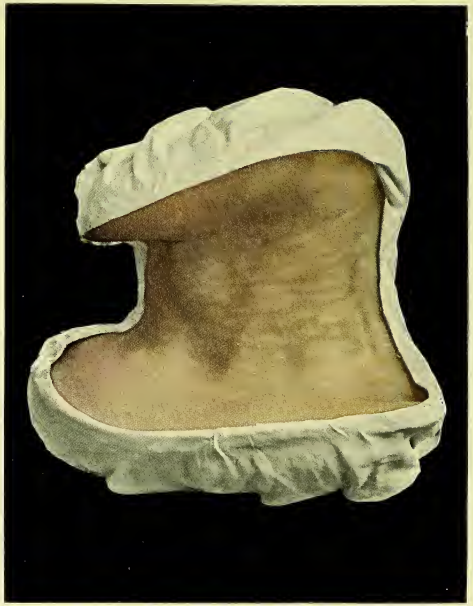
Generally speaking, the course of syphilis is nowadays very mild, but there are a certain number of cases in which extremely obstinate syphilides occur,—either after a phagedenic or after a perfectly normal primary sore,—which break down from the first or very soon afterwards; they are accompanied by severe general symptoms, fever, malaise and even cachexia. Shallow ulcers covered by stratified scabs (*Rupia syphilitica*, Fig. 147) result from the breaking down of pustules or papules and after separation of the scabs, ulcers, which are generally painful, are exposed. At the same time larger or smaller pustules and disintegrated papules are present and may be localized on the mucous membranes. Peculiar vegetations (*frambœsiform syphilides*, Fig. 148) may develop as the result of over-growth of granulation-tissue; this form of syphilide also occurs in the tertiary stage. In the majority of cases recovery ensues, although sometimes it may be very protracted. The cause of the occurrence of these atypical cases is not clear. Some authors believe that persons who suffer from malignant syphilis do so because the disease has never been present in their forefathers, or at all events not for a long time previously, so that they are not safeguarded by any acquired immunity. Other authors regard malignant syphilis as the result of a mixed infection.

The **Diagnosis** of syphilis must, as a rule, be made from observation of the characteristic manifestations described, and from a consideration of the general morbid phenomena; it is only in late syphilis that a diagnosis must frequently be established on the evidence of objective signs alone. In all cases of doubtful nature, the success or failure of treatment greatly assists diagnosis. Roseola seldom presents diagnostic difficulties if a careful examination of the patient is made; its aggravation after the administration of mercury is sometimes of assistance. Lenticular, annular, and circinate syphilides are usually recognised with ease, but the diagnosis of the lichenoid syphilide presents considerable difficulties, as it often closely simulates lichen scrofulosorum and lichen ruber; in the former disease there is much less infiltration, and lichen planus papules can be differentiated from the minute papular syphilide by their characters and arrangement, and by the occurrence of itching. In the diagnosis of papulo-squamous syphilides of the palm from eczema and psoriasis, the amount of infiltration, as well as the colour of the margins, are to be specially considered. Syphilitic leucoderma and alopecia can be recognised at a glance. Pustular syphilides, if ushered in by high fever, are sometimes mistaken for variola; but the presence of typical, lenticular papules as well as pustules, and the results of general examination (primary sore, glandular swellings, throat symptoms), will settle the difficulty. The diagnosis of gummatous and tuberous syphilides is often very difficult, especially their differentiation from lupus, rosacea, and rodent ulcer. In many cases the prompt result of treatment by iodine will facilitate the diagnosis.

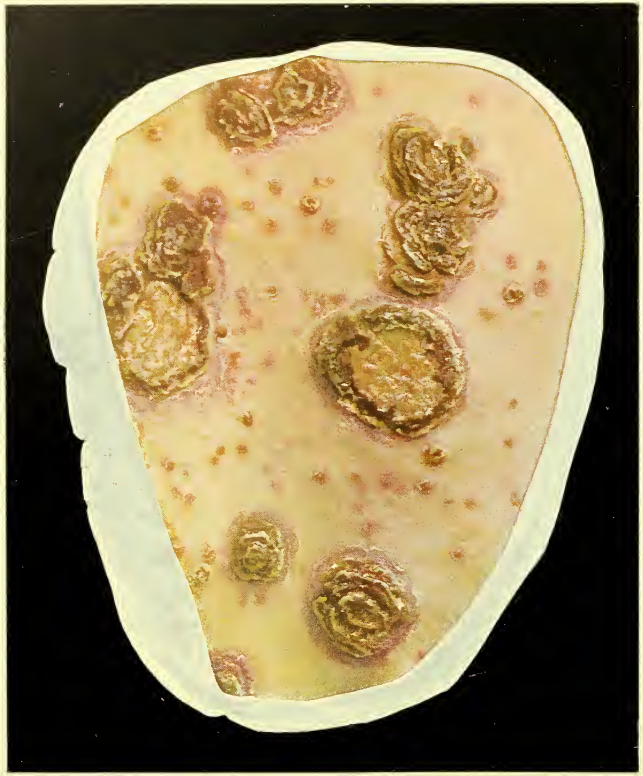
Early syphilitic manifestations on mucous membrane sometimes cause difficulties in diagnosis from simple aphthæ, pemphigus, or herpes of mucous surfaces, or



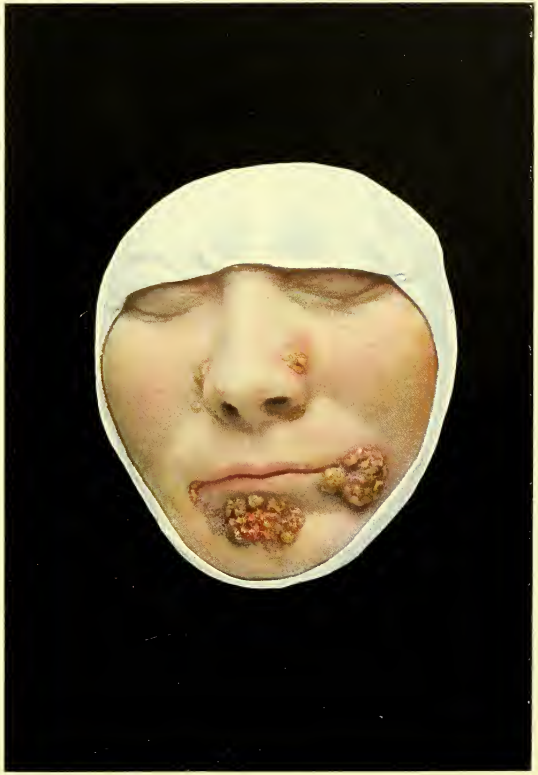
No. 145. Syphilis milio-papulosa (lichenoides).



No. 146. Leucoderma syphiliticum.



No. 147. Syphilis maligna (Rupia syphilitica).



No. 148. Syphilis framboesiformis.

from leucoplakia. Points for consideration are: the abrupt line of demarcation, the inflamed, reddened margin, the opacity of the epithelium in 'plaques opalines,' and, finally, their localization. The skin must always be carefully examined at the same time. Gummatous syphilides of mucous membranes are generally easy of diagnosis on the grounds of the sharp outline of the ulcers which result from them, and of their comparatively rapid response to treatment.

The **Prognosis** of syphilis may usually be regarded as favourable if suitable treatment is adopted; but it must be considered as dubious in untreated patients, and in a certain number of cases in which, despite treatment, late gummatous or 'parasyphilitic' manifestations appear.

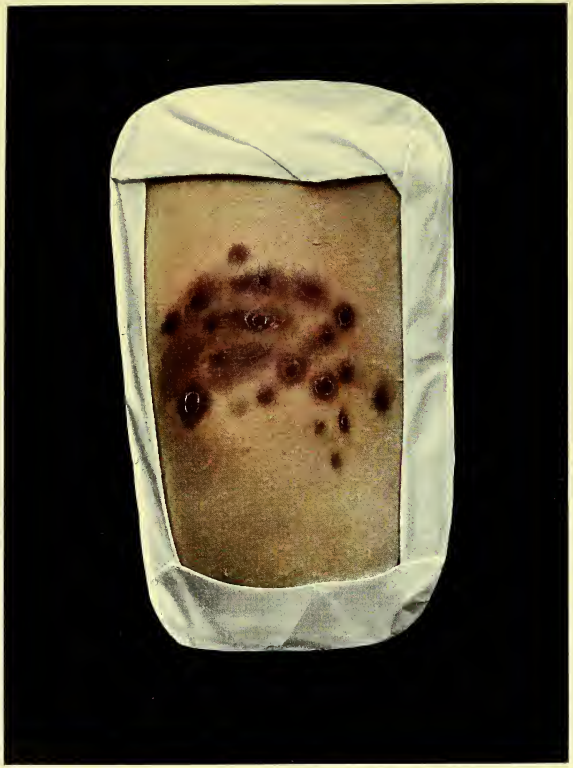
The severity of the symptoms in *hereditary syphilis*, which may be communicated to the offspring by one or both parents, depends upon the date of their syphilis, and the treatment which they have followed. If the virus is recent and severe, abortions and miscarriages result, or the children are born dead; but, subsequently, living or viable children may be born. Children with hereditary syphilis generally present a peculiarly cachectic and senile appearance, and may exhibit most of the eruptions seen in adults, but the picture is often modified by the proneness of the infantile skin to pustulate. *Pemphigus syphiliticus* is especially characteristic, and usually appears along with coryza ('snuffles'); it generally attacks the soles and palms (Fig. 154), but may affect any other part of the body. The blebs, the contents of which soon become purulent or hæmorrhagic, collapse after a brief existence, and often give rise to ulcers. There is a remarkable tendency in papular congenital eruptions to superficial extension, so that the heels, the hands,

the buttocks, and the face assume a peculiar, diffuse, brownish-red colour. Round the mouth and nose fissures and eroded papules often form, and these leave linear, radiating scars after their disappearance.

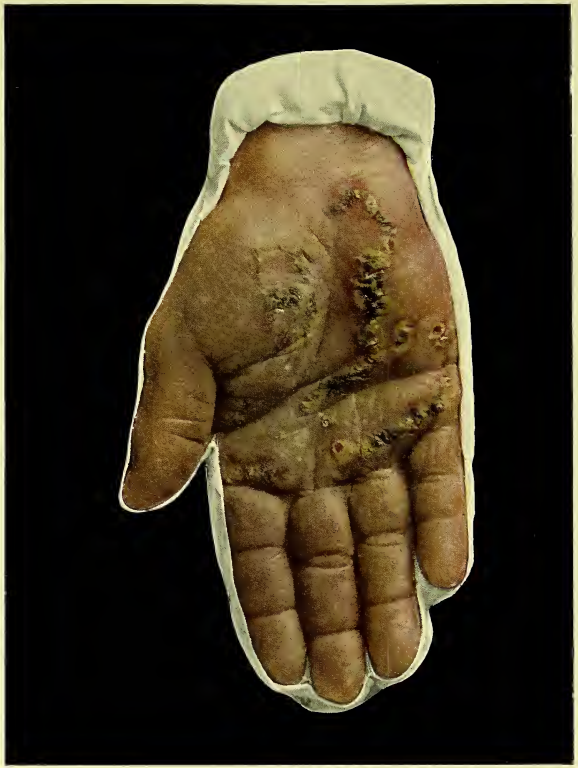
Hereditary-syphilitic children are frequently deficient in general development, and often manifest about puberty late syphilitic symptoms, identical with those of adults (*syphilis hereditaria tardiva*); destruction of the nasal bones resulting in the typical 'saddle-nose' (Fig. 155) is especially frequent. It is open to doubt whether the presence of any one of the signs known as 'Hutchinson's triad' (labyrinthine deafness, interstitial keratitis and notching of the upper central incisors) is in itself conclusive evidence of hereditary syphilis; but their simultaneous occurrence, especially if linear scars are also present about the mouth and nose, may be looked upon as a certain sign of hereditary syphilis (Fig. 155).

The **Diagnosis** of hereditary syphilis may be founded upon the eruptions, the snuffles, and the senile aspect of the child; and the diagnosis may be confirmed by treatment. The symptoms already described establish the diagnosis in most cases of late hereditary syphilis; but *syphilis hereditaria tardiva* as described by Fournier—*i.e.*, without the occurrence of lesions of the earlier stages of the disease—is not generally recognised or accepted in Germany.

**Treatment.**—The chances of warding off general infection by the operation of early, free removal of the primary sore are extremely slight. It is very easy but ought only to be practised in special cases when the sore is favourably situated (*e.g.*, on the prepuce or body of the penis), with a view to its rapid cure and to removing a certain amount of infective material and



No. 149. Syphilis tuberosa.



No. 150. Syphilis tertiaria.

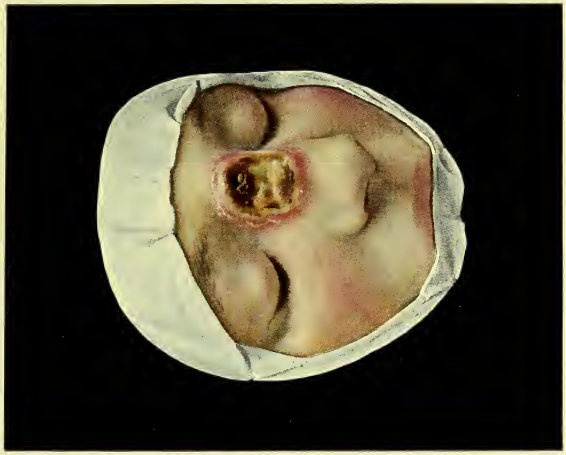
thereby, perhaps, attenuating the course of the disease; but, frequently, induration of the scar or a fresh primary sore ensues.

The treatment of doubtful erosions or sores with caustics, (especially with solid nitrate of silver), must be strongly condemned, as superficial indurations are easily produced by them and the difficulty of diagnosis is aggravated. An attempt to ward off a primary sore by energetic thermo-cauterization of any suspicious spot is more justifiable.

Fully-developed primary sores ought to be cleansed several times a day with sublimate-lotion and, if there is a moderate amount of secretion from them, dusted with calomel or dermatol, which has an almost specific action. If the sore ulcerates deeply, a solution of iodoform in alcohol and ether, or europhen may be used; if inflammation is more marked, moist sublimate-dressings or compresses may be applied. If there is only a small persistent induration with a minute amount of discharge from it, healing and absorption soon take place under mercurial plaster, which is a particularly convenient application for sores about the orifice of the urethra.

The question as to when the general treatment of syphilis should be begun is one of great importance; the usual reply is that no mercury should be given before the diagnosis is a matter of absolute certainty. As the diagnosis is first assured by the appearance of general symptoms, and as these general symptoms are not prevented by the previous administration of mercury, the correct date for the beginning of general treatment must be regarded as that of the appearance of the first eruptions. Earlier general treatment seems to us justified only when there are ulcerative or gangrenous changes in the primary sore, which do not yield to local treatment, permanent baths, iodoform, etc.

Various methods of introduction of mercury by the skin must first be mentioned. Sublimate-baths have no effect if the skin is intact, except in the form of Gärtner's bipolar baths; but if there are deep ulcers or extensive losses of epithelium, such as often occur in hereditary syphilis, they combine local with excellent general effects. Mercurial plaster, applied from time to time, is specially useful in children; painting with calomel in traumaticin, and calomel fumigations are also employed, but by far the best and safest method is by rubbing or inunction. The officinal unguentum cinereum, mercury-vasogen, or mercury-soap, and especially resorbin-mercurial ointment (which is distinguished by its cleanliness and facility of absorption) are much used, and all contain 33 per cent. of metallic mercury. The inunctions are best given in 'cyclical' fashion as first introduced by Sigmund—*i.e.*, on each day a separate part of the body is selected, so that almost the whole surface of the body has been smeared with ointment at the end of six days, and on the seventh day a bath with soap is administered for cleansing purposes. The dose for each inunction is, for children from 8 to 25 grains, for adults from 45 to 80 grains. It is preferable that the patient should do his own rubbing, 15 grains of ointment being rubbed daily for five minutes into parts which are devoid of hair. From 30 to 36 inunctions suffice for a complete course of treatment, if generous feeding is administered and careful observations of the weight are taken. In order to avoid the unpleasantness of treatment by inunction, attempts have been made to replace it by wearing a shirt impregnated with metallic mercury (merkolint-schurz) and other methods, but all are greatly inferior to well carried out inunction-treatment. The mercurial shirt may be of advantage in mild, preparatory, or subsequent courses of treatment.



No. 151. 152. Syphilis gummosa.

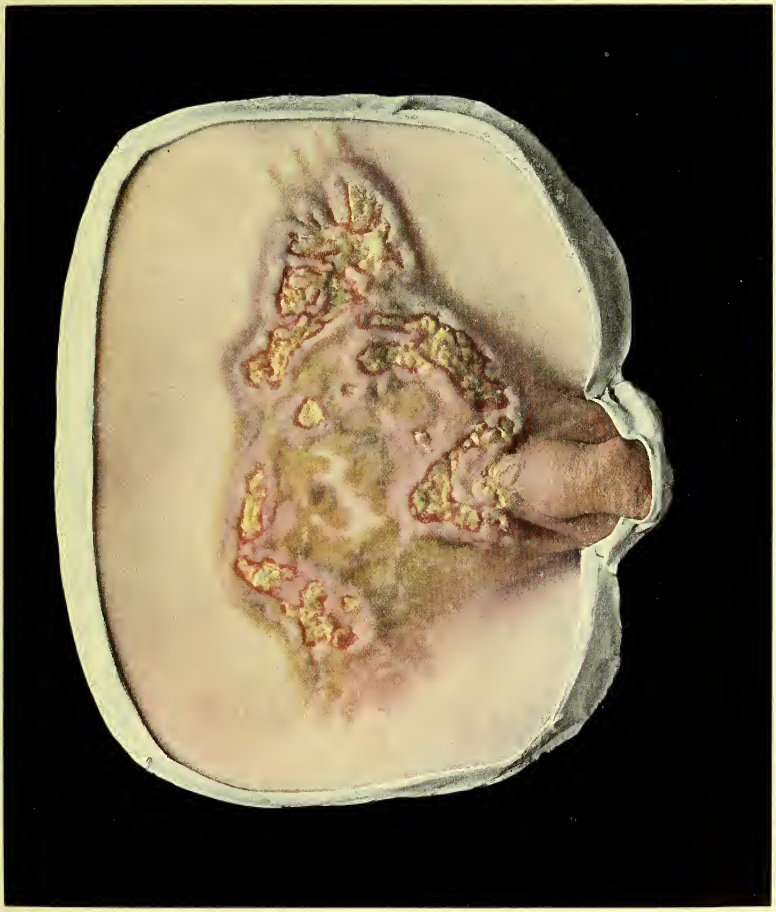
Calomel and the oxidized tannate are the only preparations of mercury which can be recommended for internal administration, and these only in hereditary and infantile syphilis, and in small doses; one pill containing 1 grain or rather more may be given twice daily. If diarrhœa should result, tannin or opium may be added to the pill. Internal treatment is, however, never to be considered as comparable with treatment by inunction.*

Mercurial injections enjoy great popularity on account of their convenience, cleanliness, and certainty of effect. Corrosive sublimate is the soluble salt most used, in the form of the Müller-Stern solution; it is composed of 1 part of sublimate and 10 of common salt in 100 parts of water, of which a Pravaz syringeful may be injected daily. The injection of larger quantities at longer intervals easily provokes symptoms of mercurial poisoning. Injections of insoluble mercurial salts are more potent and more convenient, because they are administered at longer intervals. Of these injections of calomel undoubtedly represent the most active method of mercurial treatment, and give good results even in malignant syphilis. The usual calomel injection is an emulsion of calomel in olive oil (1 : 10). Half a syringeful may be injected every four days, and, if this is borne without marked reaction, a whole syringeful may afterwards be given once a week. Salicylate of mercury and thymol-mercury are less intense in their action than calomel—which often causes enteritis or severe stomatitis—and are about equivalent in efficacy to inunctions. The treatment consists of 1 to 3 half-syringefuls at intervals of three days, and then of

* The reader need scarcely be reminded that this view is not generally entertained in Great Britain or America, where the line of treatment advocated by Professor Jacobi is, moreover, surrounded by insurmountable difficulties.—J. J. P.

a whole syringeful every fifth or sixth day, until the patient has had from six to eight injections. These injections are best made into the upper layers of the gluteal muscles, and all risk of pulmonary embolism is avoided by withdrawing the piston of the syringe after the puncture. The use of insoluble salts of mercury is contra-indicated in cachectic or weakly persons, especially in tubercular subjects, who often get hæmoptysis after them. The hygiene of the mouth must be carefully attended to in every case under mercurial treatment. The teeth ought first to be put in perfect order, and frequently brushed throughout the treatment, especially before going to bed. The mouth must be regularly cleansed with weak antiseptic and astringent lotions—*e.g.*, dilute solutions of acetate of aluminium, peroxide of hydrogen, chlorate of potash, tincture of ratanhia or myrrh ; and these measures prevent the occurrence of stomatitis in the majority of cases. Should stomatitis, however, supervene, it can usually be cured in a short time by stopping mercury and by the use of washes or pigments containing strong solutions of the substances just enumerated. Other remedies worthy of mention are balsam of Peru, nitrate of silver, hydrobromic acid, chromic acid, etc. If the patient exhibits any idiosyncrasy towards mercury he must be habituated to it by having it administered to him very gradually. Smoking must be forbidden, especially while undergoing a course of mercurial treatment.

After a course of mercury, iodide of potassium may be given with advantage, in doses of about 30 grains daily. The preparations of iodine are specially indicated in the tertiary stage of syphilis and are the chief agents employed for the rapid absorption of gummatous and tuberous new-growths, as well as for ulcers. The iodides of potassium, sodium, ammonium, lithium or strontium, are best administered in milk or



No. 153. Syphilis ulcero-serpiginosa.

mineral water; they may be given from three to six times daily and in doses up to 15 grains. Apart from coryza and iodide-acne they seldom cause troublesome symptoms. In persons who have an idiosyncrasy for iodine, and who suffer from acute, febrile iodism, iodipin is the best substitute for the alkaline iodides; a teaspoonful of the 10 per cent. solution may be given three times daily, but a more active method is by the daily subcutaneous injection of 2 drachms or more of the 25 per cent. solution, till all symptoms disappear. Simultaneously or afterwards, in the later stages, treatment with mercurials may be resumed.

Zittmann's method of treatment sometimes yields good results in late syphilis of the bones or internal organs, especially if his old formula is used. One bottle of the strong decoction—with calomel—must be taken every morning; this is followed by several hours' sweating, and in the afternoon a bottle of the weak decoction is taken cold.

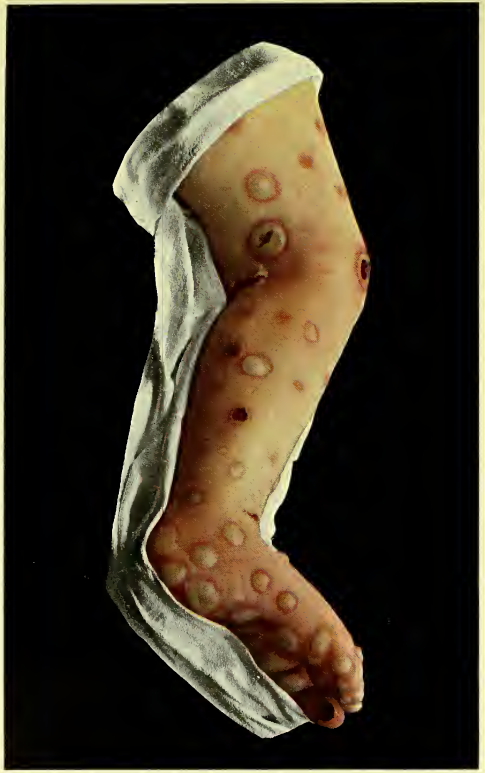
The cure of syphilitic manifestations is greatly expedited by appropriate local treatment. Papules and pustules are best treated with mercurial plaster, and this may be used for papulo-squamous syphilides of the palms and soles, after the thick horny layer has been macerated and removed by salves or plasters. Flat condylomata disappear very rapidly after painting with a thick emulsion of calomel and salt water. Cutaneous ulcers may be dusted with calomel; if there is considerable discharge from them, they may be treated with wet sublimate-dressings and afterwards dusted with iodoform. Bony sequestra must be removed after they have fully separated, and all gangrenous tissue cut away. Mucous patches may be treated by painting or spraying with sublimate-solution (1 : 1,000), with 10 per cent. solution of chromic acid, or with solid nitrate of silver; sometimes these

two latter remedies may be combined and used to produce caustic effects. Tertiary ulcers of mucous membrane generally heal without local treatment, but the process is hastened by the application of corrosive sublimate or nitrate of silver.

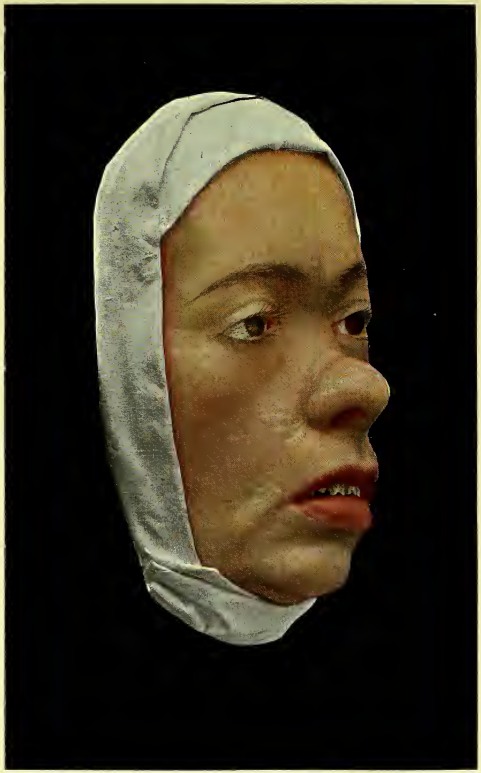
Hereditary syphilis is treated generally in the same manner as the acquired disease; the doses of drugs used must, of course, be correspondingly diminished.

Treatment must be resumed if relapses occur in the course of syphilis. If no recurrences take place the chronic-intermittent form of treatment advocated by Fournier is often of great benefit; it never does any harm if the patient is scrupulously watched, and sufficiently long pauses are regularly observed between the separate courses of treatment. Statistics of late syphilitic and 'parasyphilitic' disease offer very favourable testimony to this method of treatment.

Fig. 131. Photograph in the Freiburg Clinic.
Figs. 132, 133, 136, 145, 154, 155. Models in Lesser's Clinic in Berlin (Kolbow).
Figs. 134, 152. Models in Saint Louis Hospital in Paris (Baretta). Quinquaud's and Fournier's patients.
Figs. 135, 138, 140, 141, 142, 143, 144, 146, 147, 148, 150, 151, 153. Models in Neisser's Clinic in Breslau (Kröner).
Figs. 137, 139. Models in the Freiburg Clinic (Johnsen).
Fig. 149. Model in the Freiburg Clinic (Prof. Jacobi).



No. 154. Pemphigus syphiliticus.



No. 155. Syphilis ossium nasi.

Syphilis hereditaria.

# Ulcus Molle.

## (Soft Chancre. Chancroid.)

Plate LXXXVI., Figs. 156, 157.

A soft chancre is the result of the contamination of a more or less superficial lesion of the skin by the specific strepto-bacilli described by Ducrey and Unna. They are usually multiple and almost always situated on the genitals—being very rarely extra-genital; they appear, after an incubation period of twenty-four to forty-eight hours, as ulcers with infiltrated bases, which begin as vesicles, and they correspond in shape to the initial erosive lesions (Fig. 156). The bases of the ulcers—which are generally soft to touch—are pultaceous, the margins sharply defined but irregular in contour, and only rarely slightly-undermined. If a follicle is infected the resulting follicular chancre is excavated, from overgrowth of granulations round about (*ulcus molle elevatum*). In the course of some weeks the ulcers clear up and become benign, non-infective lesions, although up to that time capable of infinite reproduction by inoculation. In exceptional cases a large ulcer may form from extension in area and depth of the original sore, which may cause considerable destruction of tissue (Fig. 157); this may occur in perfectly healthy individuals, but is less rare in diabetic and cachectic subjects. Still more rarely does a soft chancre become

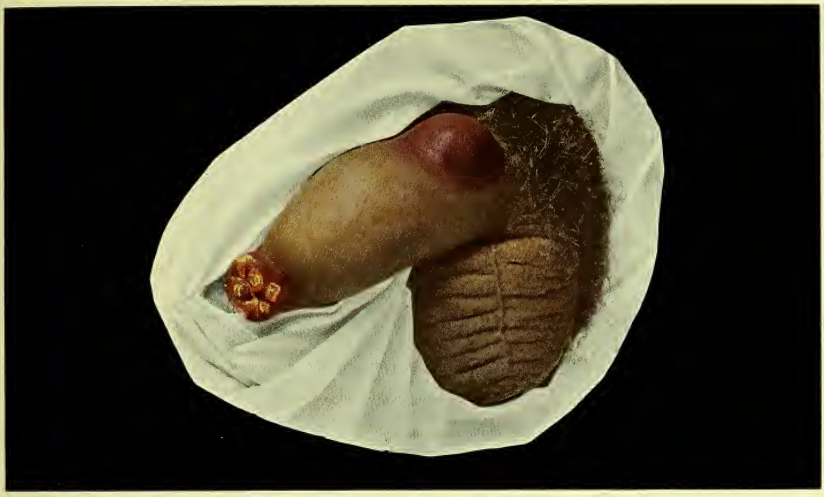
serpiginous, healing at one part and spreading at another so that, after an extremely chronic course, extensive areas of the body surface may be gradually invaded.

Soft chancre is a purely local disease and is complicated only by local participation of the lymphatic apparatus; semi-globular swellings form in the course of the lymphatic ducts (*bubonuli*, Fig. 156), which rupture outwards and sometimes simulate a true chancre. Buboes form in the neighbouring glands, and may be either simple abscesses or may simulate true chancres in appearance, after their rupture.

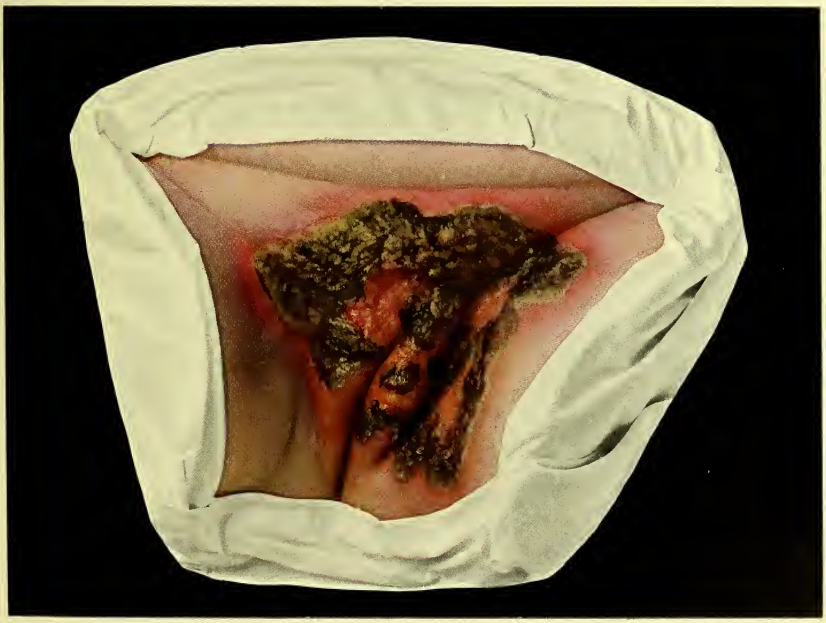
The **Diagnosis** of soft chancre is easily made in typical cases, having regard to their multiplicity and general clinical characters. Confusion with herpes progenitalis is easily avoided by bearing in mind the superficial character of herpes. The absence of cartilaginous induration and the characters of the lymphatic swellings are to be specially noted in comparing these lesions with the primary sore of syphilis. It must also be remarked that soft chancres, if improperly treated (*e.g.*, by lunar caustic), become indurated and may simulate primary sores; and that the viruses of soft chancre and syphilis may be simultaneously communicated by inoculation (*chancre mixte*). An artificial inoculation—which is a trivial matter—on the abdomen of a patient, facilitates diagnosis.

The **Prognosis** is good in common soft chancres, but must be guarded if they become serpiginous and gangrenous.

The **Treatment** of soft chancre has for its primary object the conversion of a specific sore into a common ulcer. This may be attained by cauterizing



No. 156. Ulcera mollia; Bubonulus.



No. 157. Ulcus molle gangraenosum.

with pure liquid carbolic acid or with radiant-heat from a Paquelin's thermo-cautery; iodoform may then be applied, preferably in alcoholic-ethereal solution, after which the part heals up easily with a weak nitrate-of-silver ointment. Removal under chloride of ethyl, free scraping, or thermo-cauterization, soon accomplish the same purpose. Buboes are best treated by poultices till they soften, when they must be freely opened. They may also be emptied with a trocar and a solution of nitrate-of-silver injected. Chancroidal bubonuli and buboes must be treated like common soft-sores.

Fig. 156. Model in the Freiburg Clinic (Johnsen).
Fig. 157. Model in Lesser's Clinic in Berlin (Kolbow).

# INDEX

## I. CUTANEOUS AFFECTIONS, NOT VENEREAL IN ORIGIN.

## II. VENEREAL AFFECTIONS.

---

# NUMERICAL LIST OF SUBJECTS.

## AFFECTIONES CUTANEÆ.

## AFFECTIONES VENEREÆ.